MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

CC722

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 219 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution? 219 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5 Light St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: LEONARD M. ANDERSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	divorced

6.(b) Name of husband or wife: Divorced
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 17, 1897

8. AGE: Years	Months	Days	If less than one day
49	5	18	..... hrs. ..... min.

9. Birthplace: Mississippi (Town, county, and state)
10. Usual occupation: Installer for Western Electric
11. Industry or business

FATHER
12. Name: George Anderson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Jane Gurpon
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8-1946 (month) (day) (year)
Cemetery or crematory: Arlington National Cem.
Location: Fort Myer Virginia
18. Funeral director: Odell Funeral Home Inc.
Address: 4644 York Rd. Balto. 12

19. July 7 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1946 at 12:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 28 1945 to July 5 1946 and that I last saw h... im alive on July 5 1946

Immediate cause of death	DURATION
Infarcts of Lungs	2 mos plus
Due to: Mural Thrombi of Heart	2 mos. plus
Due to: Hypertension & Coronary Thrombosis with infarction of left ventricle	7 mos plus
Other conditions: None	

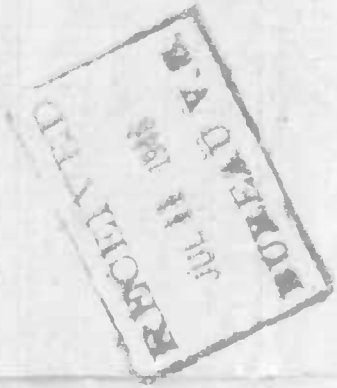
(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
ROBERT M. CULLISON, M.D. CLIN. DIR.
M. D. or other
Address: Fort Howard, Md. Date signed: 7-5-46

2400 Charles.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06723

Reg. Diat. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 4 mos., 1 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T.B.Sanatorium

How long in hospital or institution? 0 yrs., 4 mos., 1 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6507 Baltimore Ave., Dundalk, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Wallace Carl Atkins

3.(b) Social Security Number: 226-10-3371

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Shirley Atkins

8.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): August 2, 1904

8. AGE: Years	Months	Days	If less than one day
41	11	26	...hrs. ...min.

9. Birthplace: Spotsylvania, Virginia
(Town, county, and state)

10. Usual occupation: Machine Operator

11. Industry or business:

FATHER 12. Name: William Atkins

13. Birthplace: Virginia

MOTHER 14. Maiden name: Hattie Brooks

15. Birthplace: Virginia

16. Informant: Wallace Carl Atkins

Address: 6507 Balto.Ave., Dundalk, Balto.Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 31, 1946 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Spotsylvania Co., Virginia

18. Funeral director: Roland Fisher

Address: 2112 Dundalk Ave., Balto., Md.

19. July 28 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28, 1946, at 12:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1946, to July 28, 1946 and that I last saw him alive on July 28, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	About 2 Yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Silicosis	Unknown.

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other

Address: Mount Wilson, Md. Date signed: 7/28/46

Rec'd 7-31-46 Dr. E. E. Nichols mw

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06724

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: West Gate

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 6 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: West Gate near Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edmondson Ave + North Bend Lane

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Yarnall Casey Baetjer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Dr. Frederick H. Baetjer

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept 18 1875

8. AGE: Years	Months	Days	If less than one day
70	10	4	..... hrs. ..... min.

9. Birthplace: Balto Md

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Alexander Casey

13. Birthplace: Balto Md

MOTHER — 14. Maiden name: Eleanora Coale

15. Birthplace: Balto Md

16. Informant: Mrs Joseph B. Browne

Address: 342 Ingleside Ave Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July (month) 24 (day) 1946 (year)

Cemetery or crematory: Loudon Park

Location: Balto Md

18. Funeral director: Henry W. Jenkins Sons Co

Address: Mt Washington Md

19. 7-27 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1946, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 19 46 to July 22 1946 and that I last saw h alive on July 22 1946

Immediate cause of death	DURATION
Coronary Occlusion	30 hr
Due to: Cardio-Vascular Disease	1 year
Due to:	
Other conditions: Multiple Sclerosis	20 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eliot W. Johnson M.D. (M. D. or other)

Address: 3432 Frederick Ave Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. E. H. Johnson
3432 Frederick Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-J)

CERTIFICATE OF DEATH

06725 P

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No. 710 Braeside Road (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Helen Beard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Albert G. Beard
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 5 - 1867

8. AGE: Years	Months	Days	If less than one day
79	1	29	hrs. min.

9. Birthplace: Waynesboro Pa (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Frederick Dutchhart
13. Birthplace: Germany
MOTHER 14. Maiden name: Mary Helen Keepers
15. Birthplace: Baltimore Md.
16. Informant: Rebecca Beard
Address: 710 Braeside Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-16-1946 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore Md.
18. Funeral director: Flynn & Fleming
Address: 1476 Light St.
19. 7-15 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 19 46 at 7:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 45 to July 13 19 46 and that I last saw h.e alive on July 13 19 46

Immediate cause of death	DURATION
Arteriosclerotic C.V Disease	1 yr.
Due to	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. J. Lubinski C. J. Lubinski M. D. or other
Address: 5212 Harford Rd (for mailing) Date signed: 7/17/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A14

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06726

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural (Middle River)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 years
Hospital, Institution, or street address where death occurred: Bowleys Quarters Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Rural (Middle River)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bowleys Quarters Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas A. Biddison

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

8.(b) Name of husband or wife: Florence E. Biddison
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 24, 1872

8. AGE: Years	Months	Days	If less than one day
73	8	8	hrs. min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Road Maintenance
11. Industry or business: Retired

FATHER
12. Name: Thomas Biddison
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rebeccah Wilkinson
15. Birthplace: Unknown

16. Informant: Mr. Geo. A. Biddison
Address: Bowleys Quarters Road

17. burial (Burial, cremation, or removal. Which?) Date thereof: July 5, 1946 (month) (day) (year)
Cemetery or crematory: Orems Methodist
Location: Middle River, Md.
18. Funeral director: Lawrence Funeral Home
Address: 7401 Belair Road

19. 7/2 19 46 John G. Ormell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 19 46 at 1300 hr.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 19 46, to June 19 46
and that I last saw him alive on June 26 19 46

	DURATION
Immediate cause of death	
Due to: Pulmonary tuberculosis	4 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A L Kolodny M.D. M. D. or other
Address: Ridge Rd. Baltimore, Md. Date signed: July 2 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06727

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town 124 Smithwood ave Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Old Frederick Rd Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry E. Bloom

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Gussie Bloom
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11 - 3 - 1862

8. AGE:

Years	Months	Days	If less than one day
84			hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired Merchant
11. Industry or business

FATHER
12. Name Henry Bloom
13. Birthplace Md

MOTHER
14. Maiden name Rachel ?
15. Birthplace ?

16. Informant Mrs Helen Lavery
Address 124 Smithwood Ave.

17. Burial — Date thereof 7-30-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory New Cathedral
Location Baltimore

18. Funeral director Edw. J. Mc Nabb
Address Catonsville - Md

19. 7-29 1946 Harry A. Tully Registrar
(Date rec'd by registrar) Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1946 at 8 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Terminal renal failure	3 days
Due to Arteriosclerosis, generalized	Unknown
Due to	
Other conditions Myocarditis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Stephen Lee Magness MD
M. D. or other
Address 752 Frederick Ave Date signed 29 July '46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06728

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 1 month, 4 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 2 years, 1 month, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 305 Shark Street

(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: Joseph Boehmer

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1899

8. AGE: Years	Months	Days	If less than one day
47	1	10	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: helper

11. Industry or business: Friendly Inn

FATHER — 12. Name: Frank Boehmer

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Helen Ellinbrock

MOTHER — 15. Birthplace: Baltimore, Maryland

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-13-46 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore Md.

18. Funeral director: Klaus F. Evans & Son

Address: 18 W. Royal Ave. Baltimore Md.

19. 7-13 — 1946 (Date rec'd by registrar) Harry D. Mullen Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1946 at 10:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Coronary occlusion	?
Due to: Sudden Death	
Due to: Inquiry	
Other conditions: Schizophrenia	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. F. Ernsperger M.D. or other

Address: 2 Fenmore Rd. Reisterstown Date signed July 13 1946

acting Medical Examiner

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

06729

Reg. Dist. No. 39

1. PLACE OF DEATH:
County Balto.
City or town Glencoe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Glencoe.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Herbert Emanuel Bosley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	EW	

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 1, 1942

8. AGE: Years	Months	Days	If less than one day
3	11	17	____ hrs. ____ min.

9. Birthplace Glencoe, Balto. Co. Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Andrew Elmer Bosley
13. Birthplace Rayville, Balto. Co. Md.

MOTHER
14. Maiden name Catherine Virginia Bosley
15. Birthplace Rayville, Balto. Co.

16. Informant A. Elmer Bosley
Address Glencoe, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 (month) 19 (day) 46 (year)
Cemetery or crematory Wesley Chapel
Location Monkton, Md.

18. Funeral director L. Scott Brooks
Address Sparks, Md.

19. July 17, 1946 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1946, at 7 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 5, 1946, to July 17, 1946
and that I last saw h.. alive on July 16, 1946

Immediate cause of death	DURATION
Leukemia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

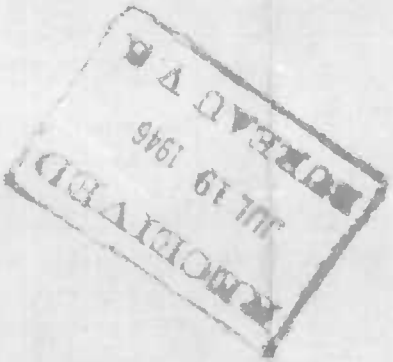
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. M. Frame M. D. or other
Address Parkton, Md. Date signed 7/17/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

06731

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 5501 EDMONDSON AVE.

Miss Hood's Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2242 Guilford ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: ANNA BRAND

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ----

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 1856 ?

8. AGE: Years	Months	Days	If less than one day
90 ?			____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Alexander Brand

FATHER — 13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Margaret ?

MOTHER — 15. Birthplace: Baltimore, Maryland

16. Informant: Miss Ethel White

Address: Severn Apartments Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/11, 1946 (month) (day) (year)

Cemetery or crematory: Cathedral

Location:

18. Funeral director: Chas. J. Evans & Son, Inc.

Address: 118 N. Mt. Royal Ave

19. 7-10-1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9, 1946, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1946, to July 9, 1946

and that I last saw h[illegible] alive on July 8, 1946

Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 wks

Due to: Cerebral Arterio Sclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: [illegible] Date signed: 7-10

DR. HOWELL
715 FREDERICK AVE.
CATONSVILLE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

05732

Reg. Dist. No. 6 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Days

Hospital, institution, or street address where death occurred: Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 7 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1206 St. Matthews St., (If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: HEZEKIAH BRINKLEY also known as HESECAR BRINKLEY

3.(b) Social Security Number: 216-09-9388

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: ////// Adeline Brinkley

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): October 31, 1890

8. AGE:

Years	Months	Days	If less than one day
55	8	12	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Unknown; 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown; 15. Birthplace: Unknown

16. Informant: Clinical Records, Vets. Adm. Hosp. Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16, 1946 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Frederick Ave., Balto., Md.

18. Funeral director: Charles R. Law

Address: 802 Madison Ave., Balto., Md.

19. 7-11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13, 1946 at 12:25 P. M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from July 6, 1946, to July 13, 1946 and that I last saw h... im alive on July 13, 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage with left hemiplegia	10 Days
Due to: Hypertension arterial	Unknown
Due to:	
Other conditions: Heart disease, hypertension and coronary arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison

ROBERT M. CULLISON, M.D. CLIN. DIRECTOR M.D. or other

Address: Fort Howard, Md. Date signed: 7-13-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

Reg. Dist. No. 490

06730

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: 239 S. Collington Ave., Balto., Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: See Above

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME

WALTER BROSNOWICK Also known as WALTER BOCHNOWICZ

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Augustus Brosnowick

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): 2-15-88

8. AGE: Years	Months	Days	If less than one day
58	5	11	....hrs. ....min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER 12. Name: John Brosnowick

13. Birthplace: Poland

MOTHER 14. Maiden name: Josephine ?

15. Birthplace: Poland

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 29/46 (month) (day) (year)

Cemetery or crematory: Holy Rosary

Location: Baltimore

18. Funeral director: Fred W Czaszewski

Address: 1930 Eastern Ave

19. 7/27 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1946 at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22, 1946, to July 26, 1946 and that I last saw h... alive on July 26, 1946

Immediate cause of death	DURATION
Heart disease - Hypertension	2 Yrs.
pulmonary, cardiac enlargement,	plus
Due to myocardial insufficiency,	
cyanosis	
Due to Pulmonary emphysema	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullerson

R. M. CULLISON, M.D. CLIN. D. M. D. or other

Address: V. A. Ft. Howard, Md. Date signed: 7-26-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06733

CERTIFICATE OF DEATH

Reg. Diat. No. 39

1. PLACE OF DEATH:

County: Baltimore

City or town: Phoenix (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Phoenix (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: — Stockton Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Rebecca Palmer Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Colored	Married

6.(b) Name of husband or wife: Thomas Brown

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Oct. 30, 1883

8. AGE:

Years	Months	Days	If less than one day
62	8	23	— hrs. — min.

9. Birthplace: Charles County, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Hanson Palmer

FATHER — 13. Birthplace: Charles Co., Md.

MOTHER — 14. Maiden name: Susan Midland

MOTHER — 15. Birthplace: Charles Co. Md.

16. Informant: Thomas Brown

Address: Phoenix, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 27 1946 (month) (day) (year)

Cemetery or crematory: St. Josephs

Location: Texas, Maryland

18. Funeral director: Landon M. Bunting

Address: Sparks Md.

19. 7/23 1946 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1946 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from after death 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary artery disease	
Due to: Cerebrovascular accident and hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Elizabeth B. Stansill, M.D. (M. D. or other)

Address: Cockeysville, Md. Date signed 7/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH 06734

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (131-a)

County Baltimore Registration Dist. No. 33

Village or City Wv Woodensburg No. Rural St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Samuel Hamilton Brown

(a) Residence: No. Old Road - Wv Woodensburg St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Marietta Brown

6. DATE OF BIRTH (month, day, and year) March 22-1862

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
84	3	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Farmer (retired)

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

FATHER

13. NAME George Brown

14. BIRTHPLACE (city or town) (State or country) unknown

MOTHER

15. MAIDEN NAME Mary ?

16. BIRTHPLACE (city or town) (State or country) unknown

17. INFORMANT Marietta Brown & children

(Address) Reisterstown, Md. R.F.D.

18. BURIAL, CREMATION, OR REMOVAL

Place Druid Ridge Date July 11, 1946

19. UNDERTAKER J. F. Elbin & Sons

(Address) Reisterstown Md.

20. FILED July 11, 1946 Mary B. Elbin Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 9 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 29, 1946, to July 8, 1946

last saw him alive on July 8, 1946; death is said to have occurred on the date stated above, at 8.10 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Chronic Cardio-Nefritis with arterio-sclerosis and B.P. 200/90	
Other Contributory Causes of Importance:	
Physical exhaustion	

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) Cyril E. Hobble M. D.

(Address) Upperco, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92E)

06735

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
20 Main Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 20 Main Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Sarah Brown

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: Charles Brown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 1, 1869

8. AGE: Years	Months	Days	If less than one day
77	4	25	..... hrs. ..... min.

9. Birthplace: Howard Co. Md.
(Town, county, and state)
10. Usual occupation: Cook
11. Industry or business
FATHER 12. Name: Andrew Collins
13. Birthplace: Howard Co. Md.
MOTHER 14. Maiden name: Sophia Collins
15. Birthplace: Howard Co. Md.
16. Informant: Marshall Brown
Address: 20 Main Ave. Catonsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30 1946 (month) (day) (year)
Cemetery or crematory: Mainus Cemetery
Location: Elkridge Howard Co. Md.
18. Funeral director: Easton Sons
Address: Ellicott City Md.
19. 7-29 1946 (Date rec'd by registrar) Harry M. Mullen Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26th 1946 at 7.30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15th 1946 to July 26th 1946 and that I last saw her alive on July 26th 1946

Immediate cause of death	DURATION
Mitral Insufficiency	3
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: C. F. Maloney M.D.
M. D. or other
Address: Catonsville Md. Date signed: 7/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ 06736

FILM No. I 06 AUG 16 1946

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Randallstown Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, institution, or street address where death occurred:

Owens Rodes

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Randallstown Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Owens Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Owen A Bryant

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	widowed

6.(b) Name of husband or wife: Amanda Bryant

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 19. 1868

8. AGE: Years	Months	Days	If less than one day
77	8	12	hrs. min.

9. Birthplace: Baltimore

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Howard Bryant

13. Birthplace: Baltimore Md

MOTHER

14. Maiden name: Eliza Tittle

15. Birthplace: Baltimore, Md

16. Informant: Noah Bryant

Address: Howardsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/2/46 (month) (day) (year)

Cemetery or crematory: Cherry Hill

Location: Granite Md

18. Funeral director: Mrs Geo. H. Holland

Address: 1631 Druid Hill Ave.

19. 7/31/46 (Date rec'd by registrar) Tom E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31, 1946, at 9:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946, to July 31 1946

and that I last saw him alive on July 30 1946

Immediate cause of death	DURATION
Cardiovascular Disease	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Tom E. Martin M. D. or other

Address: Randallstown Date signed: 7/31/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

06737

Reg. Dist. No. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

1. PLACE OF DEATH:

County Baltimore

City or town Dundalk, R. D. No. 2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1806 Rayner Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war World War #2

3. (a) FULL NAME Allen Roland Carr

3. (b) Social Security Number 219-03-2002

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1917

8. AGE: Years	Months	Days	If less than one day
28	10	20	..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Hardwood Floor Worker

11. Industry or business

FATHER 12. Name James R. Carr

13. Birthplace Baltimore Md.

MOTHER 14. Maiden name Alice G. Jolly

15. Birthplace Baltimore Md.

16. Informant Mrs. Alice G. Carr

Address 1806 Rayner Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/25/46 (month) (day) (year)

Cemetery or crematory Baltimore National Cem.

Location Baltimore Md.

19. Funeral director WM. J. TICKNER & SONS INC.

Address North & Pa Aves. Baltimore Md.

19. 7-23-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1946, at 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) DROWNING	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-21-46

Where did injury occur? Dundalk Baltimore Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Patapsco River

Means of injury Was swimming & fainted Injured at work? No

23. SIGNATURE W. B. Davis M.D. Capt. Med. Res. U.S.A. M.D. or other

Address [illegible] Date signed 7-24-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

06738

CERTIFICATE OF DEATH

Reg. Dist. No. 38

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since July 26, 1945
Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since July 26, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County City Baltimore
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1831 Gough (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Eugene Frank Casper (or) Kasprazak Jaskolewski

3.(b) Social Security Number 217-01-4835

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Nancy Casper
6.(c) If alive, give age 26 years
7. Birth date of deceased (mo., day, yr.) Sept 7, 1916

8. AGE: Years	Months	Days	If less than one day
29	5		hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Chemical Plant Worker
11. Industry or business

FATHER 12. Name Louis Jasklewski
FATHER 13. Birthplace Poland

MOTHER 14. Maiden name Sophia Casper
MOTHER 15. Birthplace Poland

16. Informant Personal History - Hospital Records
Address Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 29 46 (month) (day) (year)
Cemetery or crematory Holy Rosary
Location Germantown Rd
18. Funeral director Mark W. G. Dippel's Son
Address 2110 Belair Rd.
19. July 26 1946 (Date rec'd by registrar) Anderson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946 at 12:16 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1945 to July 26 1946
and that I last saw h.... alive on July 25 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	Since August 1941
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W A Bridges M. D. or other
Address Towson 4, Maryland Date signed 7-26-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

Reg. Diat. No. 06739 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs., 8 mos., 2 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 7 yrs., 8 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1614 Holbrook Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Miss Mary K. Caulfield

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 7, 1889

8. AGE: Years	Months	Days	If less than one day
56	10	12	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Stenographer
11. Industry or business

FATHER
12. Name: Michael F. Caulfield
13. Birthplace: Ireland

MOTHER
14. Maiden name: Delia M. Molloy
15. Birthplace: Ireland

16. Informant: Mary K. Caulfield
Address: 1614 Holbrook St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 23, 1946 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Harford Road Ritchie Hgwy., Balto., Md.

18. Funeral director: George J. Ruth, Inc.
Address: 1735 Harford Rd., Balto., Md.

19. July 19, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1946 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17, 1938, to July 19, 1946 and that I last saw her alive on July 19, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 Yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S Shaffer M.D. M.D. or other
Address: Mt. Wilson, Md. Date signed: 7/19/46

Rec'd - 7-22-46 Dr. E. Nichols

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92G)

CERTIFICATE OF DEATH

06740

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2017 North East Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Carrie Frances Chambers

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: William
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 6, 1888
8. AGE: Years: 58 Months: Days: If less than one day: hrs. min.
9. Birthplace: Wash. D. C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Joseph Duckett
13. Birthplace: Charles Co. Md.
MOTHER 14. Maiden name: Mathilda Brown
15. Birthplace: Charles Co. Md.
16. Informant: William Chambers
Address: 2017 North East Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8, 1946 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location: Baltimore Co. Md.
18. Funeral director: Mrs. Lucy A. Holland
Address: 1631 Druid Hill Ave.
19. 7-8 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 4 1946, at 11.P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-13-46 1946 to 7-5-46 1946 and that I last saw her alive on 7-5-46 1946

	DURATION
Immediate cause of death: Acute myocardities	
Due to: Mitral Insufficiency	35 days
Due to: Chr Hypertrophic Arthritis	4 yrs?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. F. Maloney M.D. M. D. or other
Address: Catonsville Md. Date signed: 7/6/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06741

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred: Veterans Administration, Fort Howard, Md.

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 917 N. Bond Street

(If rural, give LOCATION)

2.(a) If veteran, name war: World War

3.(a) FULL NAME: CHEW, William H.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Rosetta Chew

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): December 4, 1891

8. AGE:

Years	Months	Days	If less than one day
54	7	1	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: .....

FATHER — 12. Name: James Chew

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Alberta ?

15. Birthplace: Unknown

16. Informant: Clinical Records, Vets. Adm.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8 1946 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Frederick Avenue, Baltimore, Md.

18. Funeral director: Charles R. Law

Address: 802 Madison Street, Baltimore, Md.

19. 7/6 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5, 1946 at 1:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26, 1946 to July 5, 1946 and that I last saw him alive on July 5, 1946

Immediate cause of death	DURATION
ASPIRATION PNEUMONIA	9 days
Due to:	.....
Due to:	.....
Other conditions: NEURO-SYPHILIS	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: SUBSTANTIATED ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A.C.N. Robert M. Cullison

ROBERT M. CULLISON, M.D. M. D. or other

Address: V.A.F., Fort Howard, Md. Date signed 7/5/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (13-C) Reg. Dist. No. 33

06742

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Reisterstown (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Mt. Pleasant Sanatorium

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 years

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3531 Virginia Ave (If rural give location)

(e) If foreign born, how long in U. S. A.? 20 years

3 (a) **FULL NAME** Benjamin Cohen

3 (b) If veteran, name war

3 (c) Social Security No. 214-03-6921

4 Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 5, 1900

8. AGE: Years 46 Months 6 Days 23 If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation Sailor

11. Industry or business

FATHER 12. Name Charles Cohen

13. Birthplace Russia

MOTHER 14. Maiden Name Bessie Sivo

15. Birthplace Russia

16 (a) Informant Bessie Cohen (Mother)

(b) Address 1626 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-46 (month) (day) (year)

(c) Cemetery or crematory

Location Hebrew Monument Lawn

18 (a) Funeral director Jack Lewis Inc

(b) Address 1409 E Balto St

19 (a) 7/29/46 (Date rec'd by registrar) (b) A. A. Hedrick Registrar

MEDICAL CERTIFICATION

20. Date of death July 28, 1946, at 3 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1941, to July 28 1946, and that I last saw him alive on July 26, 1946.

Immediate cause of death	Duration
Myocardial Failure	
Due to Pulmonary Tuberculosis	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert F. Ahrer M. D. or other

Address Reisterstown, Md Date signed July 28, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-A

06743

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:

County: Baltimore

City or town: (Rural) Hereford (Monkton P.O.)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Hereford (Monkton P.O.) Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Jole Road

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Mary E. Cole

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1896

8. AGE: Years	Months	Days	If less than one day
47	10	1	... hrs. ... min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business:

FATHER — 12. Name: J. Emory Cole

13. Birthplace: Balto. Co. Md.

MOTHER — 14. Maiden name: Rebecca Vance

15. Birthplace: Balto. Co. Md.

16. Informant: Mrs. J. Emory Cole

Address: Monkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 9 1946 (month) (day) (year)

Cemetery or crematory: Mt. Carmel

Location: Balto. Co. Md.

18. Funeral director: Landon M. Brown

Address: Sparks, Md.

19. July 10, 1946 (Date rec'd by registrar) Miss Howard S. Markline, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6, 1946 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1946, to January 6 1946

and that I last saw h... alive on January 6 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to: Arterio Sclerosis	3 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Wilbur Bortner M. D.

M. D. or other

Address: White Hall Md Date signed: June 7. 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1572)

CERTIFICATE OF DEATH

C6744

Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County (Baltimore)
City or town White Hall (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Whitehall (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Big Falls Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Odis Collins

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 18, 1946

8. AGE: Years	Months	Days	If less than one day
[redacted]	4	10	hrs. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual occupation Infant
11. Industry or business

FATHER
12. Name Roy W. Collins
13. Birthplace Virginia

MOTHER
14. Maiden name Reba Powers
15. Birthplace Virginia

16. Informant Roy W. Collins
Address Whitehall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29, 1946 (month) (day) (year)
Cemetery or crematory Dessoops
Location Sparks, Md.
18. Funeral director Landon M. Brooks
Address Sparks, Md.

19. July 30, 1946 (Date rec'd by registrar) Mrs. Howard S. Markline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 19 46 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19 to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death Heart disease, chronic, valvular deformity, congenital (Type not further determined)	4 mo +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Bollin C. Hudson M.D. M.D. (M. D. or other)
Address Towson 4, Md Date signed 7/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

06745

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Near Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred: at Home
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rolling Road
(If rural, give LOCATION)
2.(a) If veteran, name war NS

3.(a) FULL NAME Adele Coonan

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: (none)
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): December - 1865
8. AGE: Years 80 | Months - | Days - | If less than one day ..... hrs. ..... min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Michael L. Coonan
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Adele Brenan
15. Birthplace: Baltimore

16. Informant: Mr. Edw. V. Coonan - (Son)
Address: 121 W. Lafayette - Balto Md

17. Burial, cremation, or removal. Which? Burial Date thereof July 26 46 (month) (day) (year)
Cemetery or crematory: Loraine
Location: Woodlawn Cemetery
18. Funeral director: Stewart Mortuary Inc
Address: 108 W. North Ave.
19. (Date rec'd by registrar) July 25 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July - 23 - 19 46 at 7:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec - 21 - 19 41 to July - 23 19 46
and that I last saw h.. alive on July - 23 - 19 46

Immediate cause of death	DURATION
Arterial Hypertension.	4 yrs.
Cerebral Hemorrhage.	4 yr
Due to: Arterios-Sclerosis.	4 yr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: 0 Date of op. .....
Autopsy results: D
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: 0 Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury D Injured at work?

23. SIGNATURE: S. Lloyd Johnson M.D.
M. D. or other
Address: Catonsville Md Date signed 7/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46a)

CERTIFICATE OF DEATH

1009 06746

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest towo)
How long in above place of death?
Hospital, institution, or street address where death occurred:
2 Burke Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2 Burke Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W. II

3.(a) FULL NAME: Raymond Allan Cousins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Lillian Alberta Cousins
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): September 27, 1902

8. AGE: Years	Months	Days	If less than one day
43	9	29	— hrs. — min.

9. Birthplace: Lamoine Maine (Town, county, and state)
10. Usual occupation: Captain - Merchant Marine
11. Industry or business: Isthmian Steamship Co.

FATHER
12. Name: Edmund B. Cousins
13. Birthplace: Maine

MOTHER
14. Maiden name: Jessie Edwards
15. Birthplace: Maine

16. Informant: Mrs. Lillian A. Cousins
Address: 2 Burke Ave., Towson, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: July 30, 1946 (month) (day) (year)
Cemetery or crematory: Greenmount Crematorium
Location: Baltimore Maryland

18. Funeral director: John Burns Jones
Address: Towson Maryland

19. July 29 1946 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1946, to July 26 1946
and that I last saw him alive on July 26 1946

Immediate cause of death	DURATION
Carcinoma of esophagus with metastasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jack J. Sunger M.D.
M. D. or other
Address: 506 E. North Ave Date signed: 7-28-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-7)

06747

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County Baltimore
City or town Rural - Randallstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For oowborn infants give residence of mother)
State Md. County Baltimore
City or towo Rural - Randallstown (If outside city or town limits, write RURAL and give nearest town)
Street No. Lyons Mill Road. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ellen Gertrude Crooks

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife Ross E. Crooks

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1897

8. AGE: Years	Months	Days	If less than one day
48	9	27	hrs. min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Home

FATHER
12. Name John Adams Kloke
13. Birthplace Md.

MOTHER
14. Maiden name Margaret Lanphear
15. Birthplace Md.

16. Informant Mr. Ross E. Crooks
Address Randallstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29 1946 (month) (day) (year)
Cemetery or crematory Mt Olivet Cemetery
Location Randallstown, Md.

18. Funeral director C. Harry Weer
Address Lutherville, Md.

19. 7/26/46 (Date rec'd by registrar) 19 46 Wm E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 19 46, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 42, to July 26, 19 46
and that I last saw h alive on July 25 19 46

Immediate cause of death	DURATION
Carcinomatosis	
Due to Carcinoma of pancreas	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm E. Martin M. D. or other
Address Randallstown Date signed 7/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06748

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Pikesville, Md. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 201 Hawthorne Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Seven days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Arundel

City or town Mayo Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. Edgewater, R.F.D. Md. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME William Thomas Cummings

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widowed

6 (b) Name of husband or wife Mary Virginia Gardner Cummings 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1863

8. AGE: Years	Months	Days	If less than one day
83	3	17	hrs. min.

9. Birthplace Mayo, Maryland (Town, county, and state)

10. Usual occupation Boat builder

11. Industry or business

FATHER 12. Name Wm. F. Cummings

13. Birthplace Mayo. Md.

MOTHER 14. Maiden name Eta May Gardner

15. Birthplace Eastern Shore Md.

16. Informant Mrs. Gertrude Jackson

Address Mayo Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25 1946 (month) (day) (year)

Cemetery or crematory Mayo Methodist

Location Mayo Md

18. Funeral director H. A. Hayden & Son

Address Pikesville Md.

19. 7/25 1946 (Date rec'd by registrar) E E Nichols MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1946, at 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-31-1940, to 7-23-1946, and that I last saw h[illegible] alive on 7/23/46 19

Immediate cause of death	Uremic coma	DURATION
Due to	Suppression	
Due to	Arteriosclerosis	
Other conditions	Nephritis, Chronic	
	Myocarditis, Chronic	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L. Saffell M. D. or other

Address Reisterstown MD Date signed 7/23/46

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

06749

FILM No. I 07 OCT 10 1946

CERTIFICATE OF DEATH

Reg. Dist. No. XX

1. PLACE OF DEATH:
County: Baltimore
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Cape May Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cape May Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William E. Davis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widow

6.(b) Name of husband or wife: late Grace Crum
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 6, 1874

8. AGE: Years	Months	Days	If less than one day
72	4	3	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: — Davis
13. Birthplace: —

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: Mrs. Lenora Jones
Address: Cape May Rd. Essex 21 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-12-46 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Frederick Md

18. Funeral director: Harry E. Winter
Address: 4101 Edmondson Ave.

19. 7-11 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1946, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1946, to July 9 1946
and that I last saw him alive on July 9, 1946

Immediate cause of death	DURATION
Acute Coronary Occlusion	1 hr.
Due to: Coronary Sclerosis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lenora M Jones
Address: 4711/2 Galena Ave. M. D. or other
Date signed: 7/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

06750

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Darlington
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Essa DeBoard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Avery DeBoard

6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): April 18, 1913

8. AGE: Years	Months	Days	If less than one day
33	2	28	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Rufus Jones

FATHER 13. Birthplace: North Carolina

MOTHER 14. Maiden name: Virginia Osborne

MOTHER 15. Birthplace: Virginia

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal? Which?) Date thereof July 19 1946 (month) (day) (year)

Cemetery or crematory: Darlington Cem

Location: Harford Co., Md

18. Funeral director: H. L. Bailey

Address: Darlington, Md.

19. 7-18- 1946 (Date received by registrar) Harry Jr Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 1946, at 7:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 1946, to July 16 1946 and that I last saw her alive on July 16 1946

Immediate cause of death	DURATION
Lobar pneumonia, right lower lobe	-1 week
Due to: Chronic nephritis	Indefinite
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.

Address: Catonsville-28, Maryland

July 16, 1946 Date signed

M.D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06751

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto Co
City or town: CATONVILLE MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred: CATONSVILLE CONVALENCE HOME
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: 13 Co
City or town: ARBUTUS -
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1105 ELMRIDGE -
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ANNIE M - DINNEEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife: WM. H
6.(c) If alive, give age: DEAD years

7. Birth date of deceased (mo., day, yr.): Oct 28 - 1856

8. AGE: Years	Months	Days	If less than one day
89	8	30	hrs. min.

9. Birthplace: BRISTOL, CONN -
(Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business

FATHER
12. Name: DANIEL BLACKBURN
13. Birthplace: ENGLAND

MOTHER
14. Maiden name: JOANNA DONOVAN.
15. Birthplace: IRELAND

16. Informant: JULIA C. DINNEEN
Address: 79 HIGH ST THOMASTON - Conn

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: AUG - 1 - 1946 (month) (day) (year)
Cemetery or crematory: NEW ST JOSEPH CEM.
Location: WATERBURY. CONN -
18. Funeral director: JOHN R. KENNY
Address: 1242 LEXPS. TER. ARBUTUS MD

19. 7/31 19 46 (Date rec'd by registrar) a. w. Ehrich ARS. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July - 30 1946; at 11:00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July - 10 1946, to July 30 1946 and that I last saw h alive on 19

	DURATION
Immediate cause of death: Uterine - Leiomyoma	
Due to: Chronic Myocarditis	5 yrs.
Due to: Senility	5 "
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.
Autopsy results: O
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: O Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: O Injured at work?

23. SIGNATURE: S. Lloyd Johnson M.D.
M. D. or other
Address: Catonsville Md. Date signed 7-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06752

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 5 mos., 13 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 5 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 4811 Snader Avenue (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Gertrude Doggett

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James H. Doggett
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): April 5, 1887

8. AGE: Years	Months	Days	If less than one day
59	3	8	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John T. Briley
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Barbara Vogt
15. Birthplace: Baltimore, Maryland

16. Informant: Mrs. Gertrude Doggett
Address: 4811 Snader Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 16, 1946 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemetery
Location: Reisterstown Rd., Maryland
18. Funeral director: C. Vernon Lemmon
Address: 4611 Park Heights Ave., Balto., Md.

19. July 13, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1946, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31, 1946 to July 13, 1946 and that I last saw her alive on July 13, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 Yr. 9 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Fatal Pulmonary Hemorrhage; Diabetes Mellitus (Include pregnancy within 3 months of death)	Unknown
Chronic Nephritis	6 Mos.

Major findings of operations: No operation Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. (M. D. or other)
Address: Mount Wilson, Md. Date signed: 7/13/46

Burial - 7-24-46 Dr. E. E. Nichols

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

8

06753

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 303 Bloomsbury Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Baltimore
City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No. 303 Bloomsberry Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frank Fertitta
3.(b) Social Security Number 220-14-3493

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Mary
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Jan 19 1891

8. AGE: Years	Months	Days	If less than one day
55	5	20	... hrs. ... min.

9. Birthplace Italy (Town, county, and state)
10. Usual occupation Huckster Food Market
11. Industry or business
FATHER 12. Name Vincent Fertitto
13. Birthplace Italy
MOTHER 14. Maiden name Sarah Micche
15. Birthplace Italy
16. Informant Mrs Mary Fertitto
Address 303 Bloomsberry Ave Catonsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/12/46 (month) (day) (year)
Cemetery or crematory New Cathedral
Location Baltimore Md
18. Funeral director William Cook Inc
Address 1217 W Lom... St
19. 7/11 (Date rec'd by registrar) 19 46 A W Hedrick D R Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 19 46, at 1 20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 19 46, to July 9, 46 19
and that I last saw him alive on June 9, 46 19

Immediate cause of death	DURATION
Carcinome (Primary) Right Lung	1-2 Mo
Due to ?	
Due to	
Other conditions 0	

(Include pregnancy within 3 months of death)
Major findings of operations No
Date of op.
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide 0 Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury 0 Injured at work?

23. SIGNATURE S. Lloyd Johnson M. D. or other
Address 610 FREDERICK ROAD, CATONSVILLE, MD Date signed 7/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

CERTIFICATE OF DEATH

Reg. Dist. No. 06754 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural Stoneleigh

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

711 York Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Stoneleigh Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 711 York Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Helen B. Filler

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles F. Filler

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 1, 1889

8. AGE: Years	Months	Days	If less than one day
56	9	29	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Thomas B. Pinkpoint

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Carrie B. Pudamayer

MOTHER — 15. Birthplace: Baltimore Md.

16. Informant: Charles F. Filler

Address: 711 York Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 3, 1946 (month) (day) (year)

Cemetery or crematory: Oaklawn

Location: Eastern Ave.

18. Funeral director: Wm. Cook Inc.

Address: 1217 St. Paul St.

19. 8/2 19 46 (Date rec'd by registrar) A W Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1946, at 1 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1937, to July 30 1946 and that I last saw h[illegible] alive on July 30 1946

Immediate cause of death	DURATION
Epidermoid Carcinoma with metastasis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Biopsy - cervical gland - Carcinoma Date of op. June 1946

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry L. Hanson M. D. or other

Address: 20 E. Preston St. Date signed: 7/31/46

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-6)

CERTIFICATE OF DEATH

067554 Reg. Diat. No. 43

1. PLACE OF DEATH:
County Balto Co.
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto Co.
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME J. Everett Fisher

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary E. Fisher
6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) July 2, 1867

8. AGE: Years	Months	Days	If less than one day
79		13	hrs. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual occupation Paper Hanger
11. Industry or business

FATHER
12. Name Charles E. Fisher
13. Birthplace Balto.

MOTHER
14. Maiden name Emma Borgelt
15. Birthplace Balto.

16. Informant Mary E. Fisher
Address Owings Mills Balto Co. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18, 1946 (month) (day) (year)
Cemetery or crematory Western Cemetery
Location Edmondson Ave.
18. Funeral director S. Walter May
Address 619 N. Bouldin St.

19. 7-16 1946 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1946 at 7:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6th 1946 to July 15th 1946 and that I last saw him alive on July 15th 1946

Immediate cause of death	DURATION
Chronic Myocarditis	1 yr.
Due to Coronary Sclerosis	2 yrs.
Due to Art. Sclerosis	2 yrs.
Other conditions Ca. of Urinary Bladder	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James A. Miller M.D. M. D. or other
Address Pikesville-P.O. Date signed 7/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. C. F. Hudson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06756

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County Baltimore

City or town HYDE, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:
R.F.D.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town HYde, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME John Burton Foard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife Minia Foard

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1866

8. AGE: Years	Months	Days	If less than one day
79	9	13	..... hrs. ..... min.

9. Birthplace Hyde, Maryland
(Town, county, and state)

10. Usual occupation Retired, Farmer

11. Industry or business

FATHER 12. Name Benjamin Foard
13. Birthplace Md.

MOTHER 14. Maiden name Eleanor Burton
15. Birthplace Md.

16. Informant Mr. John B. Foard
Address Hyde, Baltimore Co, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/26/46 (month) (day) (year)

Cemetery or crematory Parkwood

Location Baltimore

18. Funeral director Leonard J. Ruck

Address 5305 Harford Road-140

19. July 24 1946 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1946 at 6-10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5 1945 to July 23 1946 and that I last saw h alive on July 22 1946

Immediate cause of death Cerebral Thrombosis — DURATION 3 Mos.

Due to Hypertensive General Arterio-Sclerosis — 3 yrs.

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Clifford F. Hudson, M.D.
M. D. or other

Address Fork Md. Date signed 7/24/46

6269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (937)

Registered No. 30 B 46757

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Catonsville
(b) Street address 2 Briarwood Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Briarwood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev Ellis P Frye

3 (b) If veteran, name war	3 (c) Social Security Account No.
	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Oline Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21 - 1887

8. AGE: Years	Months	Days	If less than one day
58	8	15	hr. min.

9. Birthplace Wash D C (Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business Retired

FATHER
12. Name Noah Frye
13. Birthplace Md.

MOTHER
14. Maiden Name Alice M Brown
15. Birthplace Md

16 (a) Informant Mrs Ellis P Frye
(b) Address 2 Briarwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd
18 (a) Funeral director Edward Faulkner
(b) Address 2359 Wash Blvd
19 (a) 7-9-46 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1946, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1946, to July 6 1946, and that I last saw h[illegible] alive on July 6 1946.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to Hypertension Cardio-Vascular disease	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Nathan K. Gallagher M.D. M. D.
Address Catonsville 6-25, Md. Date signed 7-6-46

VS 150

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on

FILM No. I 07 OCT 10 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(93d)

06758

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Essex

(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. Foot Road & Marlyn Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Frederick Funke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married

6.(b) Name of husband or wife Mary Funkenhenzell 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30 - 1869

8. AGE: Years	Months	Days	If less than one day
76 77	8	23	hrs. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name William Funke

13. Birthplace Germany

MOTHER 14. Maiden name Paulus

15. Birthplace Germany

16. Informant Mrs Mary Funke

Address Route 16 Box 423 Balto 21 Md.

17. Burial Date thereof July 26-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Eastern Ave. Road

18. Funeral director John G. Connelly

Address 418 Eastern Ave. Essex

19. 7/26/46 John G Connelly

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1946 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 44 to July 24 1946

and that I last saw him alive on July 24 1946

Immediate cause of death	DURATION
Acute Pulmonary Edema	1 day
Due to Acute Arteriosclerotic Heart Disease	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard M Pennington M. D. or other

Address 417½ Eastern Ave Date signed 7/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06760

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 0 mos., 20 days
Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 0 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1233 E. Lanvale Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. Vincent C. Gately

3.(b) Social Security Number: 216-01-4511

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Bessie Gately
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): April 26, 1892

8. AGE: Years	Months	Days	If less than one day
54	2	23	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business:

FATHER
12. Name: Frank B. Gately
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Agnes Manley
15. Birthplace: Baltimore, Maryland

16. Informant: Vincent C. Gately
Address: 1233 E. Lanvale St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 22, 1946 (month) (day) (year)
Cemetery or crematory: New Cathedral Cemetery
Location: 4300 Old Fred. Rd., Balto., Md.

18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Rd., Balto., Md.

19. July 19, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1946 at 1:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29, 1946 to July 19, 1946 and that I last saw h... im ...alive on ...19...

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 Yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
...Date of op....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Stewart S Shoffer M.D. (M. D. or other)
Address: Mount Wilson, Md. Date signed: 7/19/46

Rec'd 7-22-46 - Dr E E Nichols - mw

Evidence for the change of age and birthdate is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

FILM No. G 110 MAY 21 1947 **CERTIFICATE OF DEATH**

P 06759

Reg. Dist. No. 31

1. PLACE OF DEATH
County: Baltimore
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2000 Hillcrest Road
(If rural, give LOCATION)
2.(a) If veteran, name war: No.

3. (a) FULL NAME Martin Gavel

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widower

6.(b) Name of husband or wife: Herminia Gavel
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. Oct. 9 1850 1853

8. AGE: Years	Months	Days	If less than one day
92 96			..... hrs. ..... min.

9. Birthplace: Poland
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:

MOTHER FATHER
12. Name: Not Known
13. Birthplace: Not Known
MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known

16. Informant: Emil Gavel
Address: 2000 Hillcrest Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7. 22. 46 (month) (day) (year)
Cemetery or crematory: Lorraine Park
Location: Woodlawn Md
18. Funeral director: J. Howard Stacy
Address: 3207 W North Ave
19. July 20 1946 (Date rec'd by registrar) Aw Hedrick Asst Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-19 1946, at 7 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-19 1946 to 7-19 1946 and that I last saw him alive on 7-19 1946

Immediate cause of death	DURATION
Coronary Occlusion	10 min
Due to	
Due to	
Other conditions: Arteriosclerosis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operation: None. Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None. Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: None. Injured at work?

23. SIGNATURE: D. D. Caplan M.D. Med Exam M. D. or other
Address: Reisterstown Md Date signed 7-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

067B12

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Villa Nova

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: 3620 Florida ave

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rockdale Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War #2

3.(a) FULL NAME: Wm Frederick Gleason

3.(b) Social Security Number: 216-10-0844

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 28 - 1918

8. AGE: Years	Months	Days	If less than one day
28			____ hrs. ____ min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Contracting Work

11. Industry or business: Roofing

FATHER — 12. Name: James Guyer Gleason

FATHER — 13. Birthplace: Baltimore Maryland

MOTHER — 14. Maiden name: Margret Mary

MOTHER — 15. Birthplace: Baltimore Maryland

16. Informant: James Guyer Gleason

Address: 3620 Florida ave. Rockdale Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30, 1946 (month) (day) (year)

Cemetery or crematory: Balto. National Cemetery

Location: Frederick Rd. Balto. Md.

18. Funeral director: Frank H. Newell

Address: Pikesville Maryland

19. 7-30 1946 E. Nichols Asst. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1946, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1946 to July 28 1946 and that I last saw him alive on July 28 1946

Immediate cause of death	DURATION
Crushed Chest.	
Fractured Skull	1 hr.
Due to Lacerated Forehead & Scalp	
Due to Auto accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None.

Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: July 28 '46

Where did injury occur? Villa Nova (City or town) Balto. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Public Highway

Means of injury: Auto accident Injured at work? No.

23. SIGNATURE: J. D. Caples, M. D. Medical Examiner (M. D. or other)

Address: Reisterstown, Md. Date signed: 7-29-46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06762 44

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH

County Baltimore

City or town Rural Cedar Beach Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cedar Beach Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Daisy M. Gooduin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife William J. Gooduin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 12, 1882

8. AGE: Years	Months	Days	If less than one day
64	6	8	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John H. Green

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Sue Freshour

MOTHER 15. Birthplace Maryland.

16. Informant William J. Gooduin

Address Cedar Blach. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24, 1946 (month) (day) (year)

Cemetery or crematory Mt. Calvel Cem

Location

18. Funeral director John A. Moran

Address 3000 E. Baltimore St.

19. 7-23 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1946 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946 to July 21 1946 and that I last saw h alive on July 20 1946

Immediate cause of death	DURATION
Hypertension,	
Due to Cereral Haemorrhage	
Due to acute cardiac dilitation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE allen C Bentham M. D. or other

Address 3137 E Baltimore Date signed July 23 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(932)

06763

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto

City or town Middle River . Victory Villa

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs .

Hospital, Institution, or street address where death occurred:

55 Longeron Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto .

City or town Middle River . Victory Villa .

(If outside city or town limits, write RURAL and give nearest town)

Street No. 55 Longeron Drive .

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Lewis Graham .

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Lelia B Midkiff

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 12 - 1880

8. AGE: Years	Months	Days	If less than one day
66	6		hrs. min.

9. Birthplace Mason Co. W. Va.
(Town, county, and state)

10. Usual occupation Maintenance aid .

11. Industry or business Federal Housing

FATHER 12. Name James Newman

13. Birthplace W. Va.

MOTHER 14. Maiden name Margaret Bruse

15. Birthplace W. Va.

16. Informant Lelia B. Midkiff .

Address 55 Longeron Drive .

17. ~~Burial~~ Removal Date thereof 7/26/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Huntington W. Va .

18. Funeral director John G Connelly .

Address 418 Eastern Ave. Ebey 21

19. July 26 1946 John G Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946 at 2PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1946 to July 26 1946

and that I last saw h... alive on July 26 1946

Immediate cause of death	DURATION
Acute Coronary occlusion	1 day
Due to arterio sclerotic Heart disease	14 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward M. Hummel M. D. or other

Address 711 Eastern Ave Date signed 7/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-L)

CERTIFICATE OF DEATH

06764 4 P

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Fort Howard, Maryland
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? three days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.
How long in hospital or institution? three days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County .....
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1107 North Mount Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war SAW

3. (a) FULL NAME Hamilton Green

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Divorced

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9/10/1871

8. AGE:	Years	Months	Days	If less than one day
	74	10	4	..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business

FATHER
12. Name Burton Green
13. Birthplace Harrisonburgh, Va.

MOTHER
14. Maiden name Mary Woods.,
15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17 1946 (month) (day) (year)
Cemetery or crematory Mt. Calvary Cemetery
Location Anne Arundel County, Md.

18. Funeral director Elroy Wilson
Address 1000 Brantley Ave., Balto., Md.

19. Wm. H. Outerbridge (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14th July 19 46, at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11, 1946 to July 14, 1946 and that I last saw him alive on July 14, 1946

Immediate cause of death	DURATION
Infarct of left cerebrum	4 Days
Due to Arteriosclerosis of left middle cerebral artery.	Unknown
Due to	.....
Other conditions Abscess & infarcts of spleen Mural thrombi, right auricle, partial necrosis of anterior lobe of hypophysis.	.....

(Include pregnancy within 3 months of death)
Major findings of operation ..... Date of op. .....
Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison M.D. or other
R. M. CULLISON, M.D. CLIN. DIR.
Address V.H. Ft. Howard, Md. Date signed 7-15-46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (50)

Registered No. [redacted]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 Old Frederick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED: 06765
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 810 Old Frederick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Gross

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16 1885

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm Phillips
13. Birthplace Md

MOTHER
14. Maiden Name Fannie Madden
15. Birthplace Md

16 (a) Informant Gladys McGill
(b) Address 810 Old Frederick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Wm. B. Kelson
(b) Address 1303 Presbman St.

JUL 23 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sat. July 20 1946 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9 1946, to 7-14 1946, and that I last saw her alive on 7-14 1946.

Immediate cause of death	Duration
Toxemia Hepatitis	
Due to Carcinoma of Breast Irradiated.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Wasserman M. D.
Address 1401 Eutaw Pl Date signed 7-22-46

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

★ 06766 Reg. Dist. No. 4 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Sunnie Sta, Dundalk 22 Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Sunnie Sta, Dundalk 22 Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 510 Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Adeline Swaltney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or ~~divorced~~
F	Col	yes

6.(b) Name of husband or wife: George E. Swaltney

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: 80 | Months: — | Days: — | If less than one day: hrs. — min. —

9. Birthplace: Isle of Wight Co. Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: Va

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: unknown

16. Informant: Robt. Swaltney

Address: 510 Main St. Dundalk 22 Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 7th 46 (month) (day) (year)

Cemetery or crematory: Smithfield, Va

Location: Mrs Robt A Elliott & Daughter

18. Funeral director: 1129 N. Caroline St

Address: 1129 N. Caroline St

19. July 7 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7th 1946, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to July 7th 1946

and that I last saw her alive on July 7 1946

Immediate cause of death	DURATION
Chronic Parenchymatous nephritis	unknown
Due to	
Due to	
Other conditions Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. Thomas M.D.

Address: 117 Sollers Pt. Rd Dundalk 22 Md

M. D. or other

Date signed: 7/7/46

H. McCormick Reg

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06767

Reg. Dist. No. 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred:
22 Terrace Dale
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Iowa County:
City or town: Davenport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 Hillcrest Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Walborg Berg Hammarstrom

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband ~~or wife~~: Nils Peter Hammarstrom
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 17, 1866

8. AGE: Years	Months	Days	If less than one day
80	—	11	— hrs. — min.

9. Birthplace: Sweden (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Nils W. Berg
13. Birthplace: Sweden

MOTHER
14. Maiden name: Unknown
15. Birthplace: Sweden

16. Informant: N. Walter Hammarstrom
Address: 22 Terrace Dale, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30, 1946 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18. Funeral director: John Burns' Sons
Address: Towson, Maryland

19. July 29 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28, 1946, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased ~~from~~ on that day only, to 19
and that I last saw her alive on July 28 1946

Immediate cause of death	DURATION
Coronary thrombosis	1 hour
Due to: Arteriosclerosis	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: O. Murray Fisher M. D. or other
Address: 18 E. Eager St. Baltimore. Date signed: 7/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

06768 37
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James William Hampton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~M~~ M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1862

8. AGE:

Years	Months	Days	If less than one day
84	4	6	____ hrs. ____ min.

9. Birthplace Polshot, England
(Town, county, and state)

10. Usual occupation caretaker

11. Industry or business

FATHER
12. Name James Watts Hampton
13. Birthplace England

MOTHER
14. Maiden name Anna Hampton
15. Birthplace England

16. Informant Balto. Co. Welfare Board
Address Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 6 46 (month) (day) (year)
Cemetery or crematory Sherwood
Location Cockeysville

18. Funeral director Faddon M. Brooks
Address Sparks, Md.

19. 7-6 (Date rec'd by registrar) 19 46 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 19 46 at 10 ± A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Coronary occlusion with coronary artery disease	7/4/46
Due to Chronic myocarditis	Unk.
Due to Hypertension, Arteriosclerosis	Unk.
Other conditions Senile changes	Unk.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Rollin C. Hudson MD-D.M.E.
M. D. or other
Address Towson Md Date signed 7/4/46

06769

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 33

1. PLACE OF DEATH:
County Balto.
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No. Pleasant Hill Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary M.Hanna

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joshua Hanna
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 3,18,1853

8. AGE: Years	Months	Days	If less than one day
93	2	21	..... hrs. ..... min.

9. Birthplace: Penna. (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: George Pfeffer
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Catherine
MOTHER 15. Birthplace: Penna.
16. Informant: Miss Emma Hanna
Address: Owings Mills, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 27, 1946 (month) (day) (year)
Cemetery or crematory: Reisterstown Methodist
Location: Balto. Co.
18. Funeral director: J.F.Eline & Sons
Address: Reisterstown, Md.
19. 7-27 1946 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1946 at 10:40 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8-18 1937, to 7-24 1946
and that I last saw her alive on 7-23 1946

Immediate cause of death	DURATION
Cerebral Vascular Occlusion	8 da.
Due to: arteriosclerosis	5 yrs.
Due to:	
Other conditions: Hypertensive C-V. Disease	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None.
Date of op.
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? None. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury None. Injured at work?

23. SIGNATURE: D. D. Tapley, M. D. (M. D. or other)
Address: Reisterstown, Md. Date signed July 28 '46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

06770

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, Institution, or street address where death occurred: Yk Road
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Yk Road
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME: John A. HANNIGAN.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married.

6.(b) Name of husband or wife: Esthere Hannigan
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): May - 12, 1877

8. AGE: Years: 69 | Months: 1 | Days: 21 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Felton Pa (Town, county, and state)

10. Usual occupation: Freight Office foreman

11. Industry or business: RR

FATHER
12. Name: John D. Hannigan
13. Birthplace: Yk Co. Pa

MOTHER
14. Maiden name: Mathilda Stubley
15. Birthplace: Yk Co. Pa

16. Informant: Mrs. John A. Hannigan
Address: Lutherville

17. Burial (Burial, cremation, or removal, which?) Date thereof July 8 1946 (month) (day) (year)
Cemetery or crematory: Zion Cemetary
Location:

18. Funeral director: Earl B Bury & Son
Address: Red Lion Pa

19. 7-4 (Date rec'd by registrar) 46 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1946 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 1945 to July 4 1946
and that I last saw h... alive on July 3 1946

	DURATION
Immediate cause of death: Bronchopneumonia	7-2-46
Due to: Cerebral hemorrhage	7-1-46
Due to: Hypertension	10th
Other conditions: Glaucoma	12-48

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Bennett A. Olson M. D. or other
Address: Lutherville, Md Date signed 7/4/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for the change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

FILM No. I 06 JUL 17 1946 · **CERTIFICATE OF DEATH**

06771

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Essex P.O. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 415 Beech ave
How long in hospital or institution? 22 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Balto.
City or town Essex P.O. (If outside city or town limits, write RURAL and give nearest town)
Street No. 415 Beech ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frank Heimann

3.(b) Social Security Number 213-05-9131

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife Marie
6.(c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) Aug 25 1886

8. AGE: Years	Months	Days	If less than one day
59	10		hrs. min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Butcher
11. Industry or business Schluderberg & Kurdle Co.

FATHER
12. Name
13. Birthplace Germany

MOTHER
14. Maiden name
15. Birthplace Germany

16. Informant Mrs. Marie Heiman
Address

17. Oak Lawn (Burial, cremation, or removal. Which?) Date thereof 7-8-46 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Eastern Ave.
18. Funeral director John F. Connelly
Address 418 Eastern Ave, Balto.

19. July 8 1946 John F. Connelly (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1946, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	5 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. McCarmine M.D. (M.D. or other)
Deputy Medical Examiner
Address Balto Md Date signed 7-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

8

06772 42

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: 1264 Poplar Ave

County Baltimore

City or town Arbutus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or Institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1264 Poplar Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Samuel Thomas Henry

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Bertha L. Henry

7. Birth date of deceased (mo., day, yr.) April 22, 1876 6.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
70	2	9	..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Retired Installtion Telephone Man

11. Industry or business .....

FATHER 12. Name William Henry

13. Birthplace "Do not know"

MOTHER 14. Maiden name Margaret Martin

15. Birthplace "Do not know"

16. Informant Bertha L. Henry. "Wife"

Address 1246 Poplar Ave.

17. Burial Date thereof July 3, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory London Park.

Location Baltimore Md.

18. Funeral director Dill Bros.

Address 3109 Frederick Ave.

19. 7-2 1946 A. Hobbs

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1946, at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942, to July 1, 1946

and that I last saw him alive on July 2-7 1946

Immediate cause of death	DURATION
Cerebral accident	
death sudden	Few Minutes
Due to Fx of 3rd Cervicle	
Due to in past 2 months	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. .....

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Theodore Bender M. D. or other

Address 723 Medical Arts Bldg Date signed 7-2-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

P 06773 K3

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Baltimore - rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Baltimore - rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Glenmore Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: LILLIE HOFFMANN

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Charles Hoffmann

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 4, 1879

8. AGE: Years	Months	Days	If less than one day
67	5	20	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Henry Hildebrand

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Margaret Doenges

MOTHER — 15. Birthplace: Germany

18. Informant: Miss Katherine B. Hoffmann

Address: 12 Glenmore Avenue - 6

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/27/43 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.

Address: NORTH AVE. & BROADWAY

19. 7/27/43 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 19 43, at 4 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946, to July 24th 1946 and that I last saw h[illegible] alive on July 23rd 1946.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Cardio Vascular	
Due to: Nephritis	
Other conditions: Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: 3005 [illegible] Date signed July 25 [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

AGE: dr's letter filmed 7-24-46 G106-LL
Evidence for addition of name of town where death occurred is s

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

06774 32
Reg. Dist. No.

FILM No. 106 JUL 2 3 1946

1. PLACE OF DEATH:
County Balto.
City or town Hebbville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
3304 Rolling Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Hebbville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3304 Rolling Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME AGNES HORNE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife James Horne, Sr.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Aug. 29, 1867/ 1869

8. AGE: Years	Months	Days	If less than one day
78 76	10	18	....hrs. ....min.

9. Birthplace Falkirk, Scotland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name - Morris
15. Birthplace Unknown

16. Informant Mr. James Horne, Jr., son
Address 3304 Rolling Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/20/46 (month) (day) (year)
Cemetery or crematory Loudon Park Cem.
Location Balto., Md.
18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. 7-18- 1946 (Date rec'd by registrar) E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1946 at 7:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Several Years 19.... to July 17 1946
and that I last saw h.. alive on July 16 1946

Immediate cause of death ..... DURATION
Diabetes & Nephritis Years
Due to .....
Due to .....
Other conditions Both legs H. above knees from Gangrene
(Include pregnancy within 3 months of death)
Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E E Nichols M.D.
M. D. or other
Address Pikesville md Date signed Jul 18 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06775

Reg. Dist. No. 4-38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since January 22, 1946

Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since Jan 22, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 101 Liberty
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Galdsborough T. Hubbard

3.(b) Social Security Number: 214-12-9532

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clara Hubbard

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): November 15, 1901

8. AGE:

Years	Months	Days	If less than one day
44	8		...hrs. ...min.

9. Birthplace: Cambridge Md
(Town, county, and state)

10. Usual occupation: Salesman-Public Relations

11. Industry or business:

FATHER
12. Name: William T. Hubbard
13. Birthplace: Cambridge, Md

MOTHER
14. Maiden name: Lottie M. Slack
15. Birthplace: Cambridge Md

16. Informant: Personal History - Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 7-26-46 (month) (day) (year)

Cemetery or crematory: CAMBRIDGE

Location: Cambridge Maryland

18. Funeral director: John. T. Mitchell & Sons.

Address: 1900 Eutaw Place Baltimore Md

19. July 23 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1946 at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22 1946, to July 23 1946 and that I last saw h[illegible] alive on July 22 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Since about April 1946
Due to: Tuberculosis infection	
Due to:	
Other conditions: Tuberculous enteritis	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: W. A. Bridges M. D. or other

Address: Towson 4, Maryland Date signed: 7-23-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160)

CERTIFICATE OF DEATH

06776

Reg. Dist. No. 42

1. PLACE OF DEATH:
County ~~Co.~~ BALTIMORE Co.
City or town English Consul
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
4020 Hickory ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County ~~Co.~~ Balto.
City or town Lansdowne - Halethorpe PO
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4020 Hickory ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lois Mary Hubbard -

3.(b) Social Security Number NONE.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 28 - 1946.

8. AGE: Years | Months | Days: 1 ½ | If less than one day: ..... hrs. ..... min.

9. Birthplace English Consul
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER
12. Name Louis Byron Hubbard -
13. Birthplace Mass.

MOTHER
14. Maiden name Myrtle ~~Mc~~ Spicer -
15. Birthplace Baltimore - Md.

16. Informant Louis B. Hubbard -
Address 4020 Hickory Ave. Balto 27, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30, 1946 (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

16. Funeral director Thomas W. Singleton
Address Glen Burnie, Md.

19. July 30 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1946, at 4 ft M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1946, to July 30 1946, and that I last saw her alive on July 29 - 1946

Immediate cause of death	DURATION
Cerebral Haemorrhage	36 hr.
supervening during birth -	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. L. Bacon M. D. or other
Address Linthicum - Date signed 7-29-46

VS/A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-9)

CERTIFICATE OF DEATH

Reg. Dist. No. 06777 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1111 Pratt St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3. (a) FULL NAME: JOHN ROBERT HUFF

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 21, 1899

8. AGE:

Years	Months	Days	If less than one day
46	10	18	hrs. min.

9. Birthplace: Tenn.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER — 12. Name: John Huff
13. Birthplace: Tenn.

MOTHER — 14. Maiden name: Sarah Cross
15. Birthplace: Tenn.

16. Informant: Clinical Records Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: July 12, 1946 (month) (day) (year)

Cemetery or crematory:

Location: Johnson City, Tenn.

18. Funeral director: Oler Funeral Home Inc.

Address: 4644 York Rd. Baltimore Md.

19. 7/9 1946 Miriam M. Knudsen
(Date rec'd by registrar) Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1946, at 5:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1946, to July 9 1946 and that I last saw him alive on July 9 1946

Immediate cause of death	DURATION
CARCINOMA HEAD OF PANCREAS	Unknown
Due to:	
Due to:	
Other conditions: Uremia; Pulmonary edema	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
ROBERT M. CULLISON, M.D. CLIN. DIR.
M. D. or other

Address: Fort Howard, Md. Date signed: 7-9-46

W. M. Learmonth Reg

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

06778

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Texas Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Beaverdam Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Robert Elmer Jackson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 26, 1936

8. AGE:

Years	Months	Days	If less than one day
9	9	12	hrs. min.

9. Birthplace: Balto. Co., Maryland (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business
FATHER 12. Name: Frank E. Jackson
FATHER 13. Birthplace: Balto. Co. Md.
MOTHER 14. Maiden name: Mary J. Haga
MOTHER 15. Birthplace: Smith Co. Virginia
16. Informant: F. E. Jackson
Address: Texas, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10, 1946 (month) (day) (year)
Cemetery or crematory: Jessops
Location: Sparks, Md.
18. Funeral director: Camden M. Brooks
Address: Sparks, Md.
19. 7-9 46 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1946, at 1:15 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death: Drowned, accidental (Slipped and fell into flooded quarry)	7/8/46
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accidental drowning Date of 7/8/46
Where did injury occur? Texas (City or town) Baltimore (County) Md (State)
Injured at home, farm, industry, public place (where?) Flooded quarry
Means of injury Fishing-slipped & fell in Injured at work? No

23. SIGNATURE: Rollin C. Hudson M.D. D.M.E. (M. D. or other)
Address: Towson, Md. Date signed 7/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06779 P

Reg. Dist. No. 4-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 Days

Hospital, Institution, or street address where death occurred: Vets Adm Hosp Ft. Howard, Maryland

How long in hospital or institution? 51 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 230 South Robinson St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War Two

3.(a) FULL NAME: FRANK S JANKOWIAK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 17, December, 1910

8. AGE: Years	Months	Days	If less than one day
35	7	2	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Upholsterer

11. Industry or business:

FATHER
12. Name: Michael Jankowiak
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Plucinski
15. Birthplace: Poland

16. Informant: Clinical Records Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23, 1946 (month) (day) (year)
Cemetery or crematory: St. Stanislaus
Location: Baltimore, Md

18. Funeral director: Oder Funeral Home, Inc.
Address: 4644 York Rd. Balto. Md

19. 7/22 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19, July, 1946 19 at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29, 1946 19 to July, 19, 1946 19 and that I last saw him alive on 19, July, 1946 19

Immediate cause of death	DURATION
Encysted tumor 3rd. ventricle:	Unknown
Benign tumor of brain	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R.M. CULLISON, M.D. CLIN. DIR. 7/19/46

Address: Fort Howard, Md Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

CERTIFICATE OF DEATH

★ 0678414

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 729 days

Hospital, institution, or street address where death occurred: Veterans Administration, Fort Howard, Md.

How long in hospital or institution? 729 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 33 Hutton Place

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: JENSON, Nathan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Mrs. Matilda Jenson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 5/23/88

8. AGE: Years	Months	Days	If less than one day
58	1	13	..... hrs. ..... min.

9. Birthplace: Churchton, Maryland (Town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business

FATHER — 12. Name: Nathan Jenson

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sara Frandany

15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm.

Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/10/46 (month) (day) (year)

Cemetery or crematory: Ft Bamblin Cem

Location: Churchton, Maryland

18. Funeral director: J. B. Johnson

Address: 34 Lafayette Ave., Annapolis, Md.

19. July 8- 46 Dawson T. Harbin

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 19 46 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 19 44, to July 6 19 46 and that I last saw him alive on July 6 19 46

Immediate cause of death	DURATION
Cerebral Thrombosis	
Cerebral Arteriosclerosis	8 mos.
Due to: Arteriosclerosis, generalized	plus
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: VFS. Robert M. Cullison ROBERT M. CULLISON, M.D. M. D. or other

CLINIAL DIRECTOR

Address: FORT HOWARD, MD. Date signed: 7-6-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

46781

8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 89 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 89 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 422 First Street
(If rural, give LOCATION)

2.(a) If veteran, name war WW I

3.(a) FULL NAME George E. Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Ester Johnson

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) March 22, 1895

8. AGE: Years	Months	Days	If less than one day
51	4	2	...hrs. ...min.

9. Birthplace Annapolis, Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name George H. Johnson
13. Birthplace Maryland

MOTHER
14. Maiden name Sheli Washington
15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/46 (month) (day) (year)

Cemetery or crematory National Cemetery

Location West St. & Rd. Annapolis Md

18. Funeral director Mrs Charles B. Hilks

Address 45 Northwest St. Annapolis Md.

19 July 26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1946, at 6:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1946, to July 24 1946 and that I last saw him alive on July 24 1946

Immediate cause of death	DURATION
TUBERCULOSIS CHRONIC PULMONARY	89 Days
FAR ADVANCED ACTIVE	Plus
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M. D. CLIN. DIRECTOR
M. D. or other

Address Ft. Howard, Md. Date signed 7-25-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

06782

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Catonsville Convalescent Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va County: Berkeley

City or town: Martinsburg W. Va

(If outside city or town limits, write RURAL and give nearest town)

Street No.: W. Burke St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Ella Irene Jolliffe

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: W. S. Jolliffe

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 7, 1871

8. AGE:

Years	Months	Days	If less than one day
74	7	3	..... hrs. ..... min.

9. Birthplace: Martinsburg W. Va (Town, county, and state)

10. Usual occupation: Home duties

11. Industry or business: Home

FATHER — 12. Name: Frederick Spillman

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Susan Catherine Shook

15. Birthplace: Berkeley Co. W. Va

16. Informant: F. P. Spillman

Address: Martinsburg W. Va

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/10/46 (month) (day) (year)

Cemetery or crematory: Green Hill

Location: Martinsburg W. Va.

18. Funeral director: Easton & Sons

Address: Ellicott City, Md.

19. 7-10 1946 (Date rec'd by registrar) Harry L. Fuller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1946, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1944, to July 9 1946

and that I last saw h.. alive on July 9 1946

Immediate cause of death	DURATION
Hypostatic pneumonia, bronchial	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jno. A. Kuhn M.D. M. D. or other

Address: Ellicott City, Md. Date signed 7/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

P 06783

Reg. Diat. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore, County

City or town: Baltimore Highlands
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore Highlands
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2917 Virginia Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles F Keil

3. (b) Social Security Number: 212-12-7800

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Olymphia

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1, 1869

8. AGE: Years	Months	Days	If less than one day
77	2	11	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER — 12. Name: John F. Keil

FATHER — 13. Birthplace: Balto. Md.

MOTHER — 14. Maiden name: Mary Augusta (Unknown)

MOTHER — 15. Birthplace: Balto. Md.

16. Informant: Charles E Keil

Address: 2917 Virginia Ave, Baltimore Highlands

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15, 46 (month) (day) (year)

Cemetery or crematory: Western

Location: Baltimore, Md.

18. Funeral director: Wm Cook Inc.

Address: 1217 St Paul St., Baltimore, Md.

19. July 15 19 46 (Date rec'd by registrar) accepted [illegible] (Registrar)

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: July 12, 1946, at 9:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/12, 1946 to 7-12 1946 and that I last saw h[illegible] alive on 7-12 1946

Immediate cause of death	DURATION
Acute Cardiac Failure	1 da
Due to Generalized Arteriosclerosis	
Due to Cardiac Failure Dyspnea	5 yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Joseph H Carmichael M.D. M. D. or other

Address 679 Washington Blvd Date signed 7/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06784

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 3027 Lynwood Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Parkville (If outside city or town limits, write RURAL and give nearest town)

Street No. 3029 Lynwood Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Kinderwater

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary M.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 3. 1885

8. AGE: Years: 61 | Months: 1 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Philadelphia Pa. (Town, county, and state)

10. Usual occupation: Grain

11. Industry or business: Retail Distillery

FATHER — 12. Name: Charles D. Kinderwater

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Josephine Wolf

MOTHER — 15. Birthplace: Philadelphia Pa

16. Informant: Mary Kinderwater

Address: 3029 Lynwood Ave, Parkville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 1 46 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Taylor Ave Parkville

18. Funeral director: William Cook Inc

Address: 1217 St Paul Street

19. 7/31 19 46 (Date rec'd by registrar) A.W. Hedrick AMS Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 19 46, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 19 45 to July 29 19 46 and that I last saw h alive on July 29 19 46

Immediate cause of death	DURATION
Acute Cardiac Dilatation	July 29 1946
Due to:	
Due to:	
Other conditions: Chronic Myocarditis	A recurrent 07 years.

(Include pregnancy within 3 months of death)

Major findings at operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Morris B. Green MD (M. D. or other)

Address: 3009 Evergreen Av Date signed: 7/30/46 Balto 14 Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-a)

06785

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 1 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3019 Belmont Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war SAW ✓

3. (a) FULL NAME CAMPBELL M. KING

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Rosa King

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-3-73

8. AGE:

Years	Months	Days	If less than one day
72	7	28	..... hrs. ..... min.

9. Birthplace Knoxville, Tenn.
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-2-1946 (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery
Baltimore, Md.

Location .....

18. Funeral director Odor Funeral Home Inc.
Address 4644 York Rd., Balto., Md.

19. 8/2 19 46 A W Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1946, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30, 1946 to July 31, 1946 and that I last saw him alive on July 31, 1946

Immediate cause of death	DURATION
Carcinoma of Larynx with	
Metastasis to right side of neck	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. CLIN. M. D. or other

Address V.A.Ft. Howard, Md. Date signed 8-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

16786

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 145 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Ft. Howard, Md.
How long in hospital or institution? 145 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 636 Wyeth St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: JOHN F. KIRSCHBAUM

3.(b) Social Security Number: 212-07-0898

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Deceased
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 15, 1897

8. AGE: Years	Months	Days	If less than one day
49	2	14	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Guard
11. Industry or business

FATHER
12. Name: Frederick Kirschbaum
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Elizabeth Stanger (Dead)
15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/2/46 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: St. Baltimore, Maryland

18. Funeral director: Wm. Cook Inc.
Address: 1217 St. Paul St., Balto., Md.

19. 7/31 1946 (Date rec'd by registrar) A. A. Hedrick Registrar
ams

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1946 at 7:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1946, to July 29 1946 and that I last saw him alive on July 29 1946

Immediate cause of death	DURATION
CORONARY OCCULISON	Sudden
ACUTE	
Due to: Heart disease - coronary	
arteriosclerosis	unknown
Due to:	
Other conditions: Carcinoma of the prostate	
Arthritis, chronic acute exacerbation	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison M.D. ROBERT M. CULLISON, M.D. CLIN. DIR.
M. D. or other
Address: Vets. Adm. Ft. Howard, Md. Date signed: 7-29-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

07467

Reg. Dist. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Baltimore - Rural, Pikesvil

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 305 Reisterstown, Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MARGARET C. KRUMM

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Henry W. Krumm

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): January 8, 1868

8. AGE: Years	Months	Days	If less than one day
78	6	21	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Charles Kahl

13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Katherine Siefert

15. Birthplace: Germany

16. Informant: Henry W. Krumm

Address: 305 Reisterstown Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/1/46 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemetery

Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.

Address: NORTH AVE. & BROADWAY

19. 7-30 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A. M

20. DATE OF DEATH: July 29 1946, at 11.4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1946, to July 29 1946 and that I last saw h.e.r alive on July 28 th 1946

Immediate cause of death	DURATION
Intestinal Obstruction	6 ds.
Due to: Enteric Sclerosis	unknown
Due to: Malignancy in intestinal tract Cancer	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. B. Eulon M. D. or other

Address: 720 York Rd. Date signed 7-30-46

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93d) Reg. Dist. No. 44

CERTIFICATE OF DEATH

06787

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Raspeburg (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Philadelphia Road
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Raspeburg (If outside city or town limits, write RURAL and give town)
(d) Street No. Philadelphia Road (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Frank Joseph Kuehne

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex M | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ada M. Kuehne

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1894

8. AGE: Years 51 | Months 8 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Electrician

11. Industry or business House Wiring

FATHER
12. Name Robert Kuehne
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Hax
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Frank J. Kuehne
(b) Address Phila. Rd. Box 357, Balto. 6, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7/23/46 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Stemmers Run, Md.

18 (a) Funeral director Kassalow Funeral Home
(b) Address 7401 Belair Road

19 (a) July 21 46 (Date rec'd by registrar) (b) John D. Cornell Registrar

MEDICAL CERTIFICATION

20. Date of death July 20 1946, at 11:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1946, to July 20 1946, and that I last saw him alive on July 20 1946.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arterio-Sclerotic Cardio vascular disease	
Due to	
Other conditions Thrombo-angyitis obliterans extremities (Include pregnancy within 3 months of death)	15 yrs

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo M. Baumgardner M.D. M. D. or other
Address Balto 6 Md Date signed 7-20-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

C6788

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months, 20 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 11 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore -8

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Campfield Road (Augsburg Home)

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Emma Laage

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1864

8. AGE: Years: 82 | Months: 4 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: Rosenberg, Germany (Town, county, and state)

10. Usual occupation: Personal maid

11. Industry or business: Household

FATHER 12. Name: Adolph Laage

FATHER 13. Birthplace: France

MOTHER 14. Maiden name: ? Redtke

MOTHER 15. Birthplace: Prussia, Germany

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-3-46 (month) (day) (year)

Cemetery or crematory: London Park

Location: Frederick Road

18. Funeral director: John A. Miller Jr.

Address: 2435 E. Oliver St

19. 8/1 (Date rec'd by registrar) 19 46 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 19 46, at 10:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10 19 45, to July 30 19 46 and that I last saw h er alive on July 30 19 46

Immediate cause of death	DURATION
Chronic myocarditis	Indefinite
Due to: Generalized arteriosclerosis	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.

M. D. or other

Address: Catonsville-28, Md. Date signed: 7-31-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

CERTIFICATE OF DEATH

C6789

Reg. Diat. No. 39

1. PLACE OF DEATH:
County Balto.
City or town Jacksonville, Phoenix Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Jacksonville, Phoenix
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Leonard Martin Lins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Catharine Linty
6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1866

8. AGE:

Years	Months	Days	If less than one day
79	9	24	hrs. min.

8. Birthplace Long Green, Balto Co. Md.
(Town, county, and state)
10. Usual occupation Builder
11. Industry or business
FATHER 12. Name John C. Lins
13. Birthplace Germany
MOTHER 14. Maiden name Margaret Decker
15. Birthplace Germany.
16. Informant Mrs. L. M. Lins
Address Phoenix, Md.
17. Burial Date thereof 7 15 46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Evangelical Reform
Location Jacksonville, Balto Co. Md.
18. Funeral director Landon M. Brooks
Address Sparks, Md.
19. July 15 1946 Anna Price
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1946 at 11 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1942 to 7/12 1946
and that I last saw h. alive on 7/11 1946

Immediate cause of death	DURATION
Carcinoma (Prostate & Bladder)	3 yrs
Due to	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma
Date of op. 1942
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Hilmer C. Evans M.D.
M. D. or other
Address Cockeysville Md. Date signed 7/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 43

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Baltimore County

(a) Baltimore City, Maryland

(b) Street address 5225 Hamilton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County 06790

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5225 Hamilton Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE A. LUTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Wm. H. Lutz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 11, 1868

8. AGE: Years	Months	Days	If less than one day
77	10	9	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name J. H. Koppelman

13. Birthplace Balto., Md.

MOTHER

14. Maiden Name Anna Weber

15. Birthplace Germany

16 (a) Informant Mr. Geo. W. Lutz

(b) Address 5225 Hamilton Ave.

17 (a) burial (b) Date thereof 7/23/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Balto., Md.

18 (a) Funeral director Lanahan Funeral Home

(b) Address 7401 Belair Road

19 (a) July 22 (b) Mae L. Reifsnider
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20th, 1946 at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1945, to July 20 1946, and that I last saw her alive on July 20 1946.

Immediate cause of death	Duration
Cardio-vascular disease	Many yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature A. L. Hutchinson

Address 5713 Bel Air Rd Date signed 7/21/46
M. D.

Balt 6

VS 150

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

06791

8

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Kingsville md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Kingsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Louis Mazor
3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Mary Mazor
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Not known ?
8. AGE: Years: About 61 Months Days If less than one day ... hrs. ... min.
9. Birthplace: Russian (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: ? Mazor
13. Birthplace: Russian

MOTHER
14. Maiden name: not known
15. Birthplace: Russian

16. Informant: Mr. Donald Mazor
Address: Kingsville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 23, 1946 (month) (day) (year)
Cemetery or crematory: Holy Trinity Russian
Location: Stoney Run, A.A.Co.
18. Funeral director: Joseph A. Grebliunchas
Address: 423 S. Paca St
19. July 22 1946 (Date rec'd by registrar) A W Hedmuth per odd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1946 at 7:15 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 8, 1945 to July 21 1946
and that I last saw h___ alive on July 21 1946

Immediate cause of death: Cardiac embolism — DURATION: 15 min.
Due to: Thrombophlebitis Lt. Saphenous Vein — 3 wks
Due to: Infarct rt. lung — 6 days
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Clifford F. Hudson, M.D. M. D. or other
Address: Fork, Md. Date signed: 7/21/46

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

FILM No. I 06 JUL 26 1946

C6792

Reg. Diat. No. 44

1. PLACE OF DEATH:
County: Balto.
City or town: Essex 21 Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days.
Hospital, institution, or street address where death occurred: Rockenbacks Rd #1605
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: North Carolina. County:
City or town: Salisbury.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 518 N. Cockrell St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Eugene Lawson McCubbins.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Louise L.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 15/1882

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace: Salisbury, N.C. (Town, county, and state)
10. Usual occupation: R.R. employee Retired
11. Industry or business

FATHER
12. Name: Thomas Mc Cubbins
13. Birthplace: N.C.

MOTHER
14. Maiden name: Lula Torrens
15. Birthplace: N.C.

16. Informant: Louise L Mc Cubbins
Address: 1605 Rockenbacks Rd
17. Removal (Burial, cremation, or removal. Which?) Date thereof 7 11 46 (month) (day) (year)
Cemetery or crematory:
Location: Salisbury N.C.
18. Funeral director: James J Bruderick
Address: 1407 Eastern Ave.
19. 7/11 1946 A.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1946 at 3 45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	Immediate
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J M Carmine M.D.
M.D. or other
Deputy Medical Examiner
Address: Salisbury Md Date signed 7/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-1)

CERTIFICATE OF DEATH

C6793

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Ellicott City, Balto. Co.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
River Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: River Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Miller

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 7, 1856

8. AGE:

Years	Months	Days	If less than one day
90	1	29	..... hrs. ..... min.

9. Birthplace: Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation: Weaver

11. Industry or business: Silk Mill

FATHER
12. Name: Joseph F. Miller

13. Birthplace: Germany

MOTHER
14. Maiden name: Barbara Steiger

15. Birthplace: Germany

16. Informant: Miss Barbara E. Miller

Address: River Road Ellicott City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 2 1946 (month) (day) (year)

Cemetery or crematory: St. John's Cemetery

Location: Ellicott City, Md.

18. Funeral director: Easton Sons

Address: Ellicott City, Md.

19. 7-31 1946 (Date rec'd by registrar) Harry D. Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1946, at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to 7/30 1946

and that I last saw her alive on 7/30 1946

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — DURATION: 3 years

Due to:

Due to:

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George E. Buxton M.D.
M. D. or other

Address: Ellicott City, Md. Date signed: 7/31/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 30 (6794)

1. PLACE OF DEATH:
County 5313 Edmondson Ave Balto. Co.
City or town Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, Institution, or street address where death occurred:
Mt. Hood Sana
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3501 Gelenmount Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Catherine Eliz. Mumma

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Wm. L. Mumma

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 23, 1870

8. AGE: Years	Months	Days	If less than one day
76	2	25	____ hrs. ____ min.

9. Birthplace Balto. City (Town, county, and state)
10. Usual occupation Housework
11. Industry or business At Home

FATHER
12. Name Andrew Bowers
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace Germany

16. Informant Mrs. Frances O. Burns
Address 702 E. 30th St.

17. Burial Date thereof 7 22 46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery ~~or crematory~~ London Pk.
Location 3801 Frederick Rd.
18. Funeral director Elmer H. Conplin & Son
Address 924 E. Eager St. Balto 2 Md.

19. 7-20 1946 Harry J. Miller Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 July, 1946, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 July 1946, to 18 July 1946 and that I last saw h-er alive on 17 July 1946

Immediate cause of death	DURATION
Broncho pneumonia	2 days
Due to Cerebral hemorrhage	4 days
Due to Cerebral arteria sclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Stephen Lee Magness MD
M. D. or other
Address 752 Frederick Ave Date signed 19 July 46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

C6795

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Westown, Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Hoods Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Westowne, Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No.: Edmondson North Bend Rd (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ferdinand J Muth

3.(b) Social Security Number:

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary C Muth
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Apr 17 1868
8. AGE: Years 78 Months 3 Days — If less than one day ... hrs. ... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Wm Muth
13. Birthplace: Germany
MOTHER 14. Maiden name: Not Known
15. Birthplace: " "
16. Informant: Ferdinand J Muth Jr
Address: 5307 Old Frederick Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-19-46 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore Md
18. Funeral director: Geo. A Gritz
Address: Catonsville Md
19. 7-18- 194 (Date rec'd by registrar) Harry W. Miller, Deputy, Registrar

MEDICAL CERTIFICATION

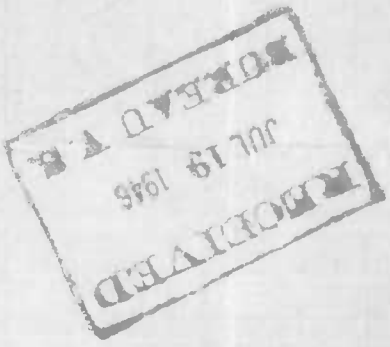
20. DATE OF DEATH: July 17 1946, at 9:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 10 1942 to July 17 1946
and that I last saw him alive on July 17 1946

Cause	DURATION
Immediate cause of death: Pulmonary Edema	2 das.
Due to: Arteriosclerotic Heart Dis	4 yrs.?
Due to: Cerebral Hemmorhage	2 wks.
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: George Elliott M. D. or other
Address: 803 ... Ave, Catonsville 28 Md. Date signed: 7-18-46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JUL 19 1945
BUREAU T.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

A6796

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Brooklyn, Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 9003 Victory Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James Myerly (JAMES ALGER MYERLY)

3.(b) Social Security Number: 216-03-5851

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single (Divorced)

6.(b) Name of husband or wife: - Carrie Myerly

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August-27-1900

8. AGE: Years	Months	Days	If less than one day
45	11	4	..... hrs. ..... min.

9. Birthplace: ? (Town, county, and state)

10. Usual occupation: Railroad worker

11. Industry or business: Railroad

FATHER 12. Name: ? Myerly (Claude Myerly)

FATHER 13. Birthplace: ? Carroll Co., Md.

MOTHER 14. Maiden name: Madie ? (Matie Bowers)

MOTHER 15. Birthplace: ? Carroll Co., Md.

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 2, 1946 (month) (day) (year)

Cemetery or crematory: Meadow Branch

Location: near Westminster, Maryland

18. Funeral director: Stewart & Mowen Company

Address: 108 W. North Ave., Balto., Md.

19. 8/ 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 46, at 9:05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 19 46, to July 31 19 46 and that I last saw him alive on July 31 19 46

Immediate cause of death	DURATION
Central nervous system syphilis	approx. 6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 7-31-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

06797 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-P)

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Balto

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? (40) Raspeburg

Hospital, institution, or street address where death occurred: 6006 Kenwood Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6006 Kenwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Pearl S. Hanlon (or) Pearl S. Myers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband (or wife): Earl H. Myers

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Oct 13 1894

8. AGE: Years	Months	Days	If less than one day
51	9	18	hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

FATHER — 12. Name: Peter Petrzuski

13. Birthplace: Poland

MOTHER — 14. Maiden name: Pauline Wasilewska

15. Birthplace: Poland

16. Informant: Earl H. Myers

Address: 6006 Kenwood Ave

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) 8 (day) 3 (year) 46

Cemetery or crematory: Holy Redeemer

Location: 4300 Belair Rd

18. Funeral director: Mat. W. Dipple's Sons

Address: 710 Belair Rd

19. (Date rec'd by registrar) 8/5 19 46 A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 46 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 19 45 to July 31 19 46 and that I last saw h.. alive on July 28 19 46

Immediate cause of death: Carcinoma Uteris — DURATION: 8 Mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Hardesty M. D. or other

Address: 4810 Belair Rd Date signed Aug 7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

06798

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Arcadia
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, institution, or street address where death occurred: Trenton Rd
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto
City or town: Arcadia Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Trenton Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: James Walter Nash

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1871

8. AGE:

Years	Months	Days	If less than one day
74	10	12	...hrs. ...min.

9. Birthplace: Cedar Grove, Balto Co., Md. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business: Agriculture
FATHER — 12. Name: Joseph Neal
FATHER — 13. Birthplace: Maryland
MOTHER — 14. Maiden name: Matilda Cole
MOTHER — 15. Birthplace: Mary Land
16. Informant: Mrs Irvin Leonard
Address: Upperco Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-17-46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Grace Baltimore Co. Md.
18. Funeral director: Jacob Winks Sons
Address: Manchester Md
19. July 15 1946 (Date rec'd by registrar) Cecil E. Fowble M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1946, at 1 45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 27 1946 to July 15 1946 and that I last saw him alive on July 14 1946

Immediate cause of death: Cardio-Vascular Disease — DURATION: Final
Due to: Chronic Myocarditis — DURATION: ?
Due to: — DURATION:
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: Joseph E. Bush M.D.
M. D. or other
Address: Hampstead Md. Date signed: 7-15-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12ta)

CERTIFICATE OF DEATH

06799 Reg. Dist. No. 38

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Ruxton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Ruxton (If outside city or town limits, write RURAL and give nearest town)
Street No. Berwick ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Louis O'Donnell
3. (b) Social Security Number none

4. Sex ~~White~~ Male
5. Color or race ~~Male~~ White
6.(a) Single, married, widowed, or divorced Widower
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Sept 10, 1876

8. AGE:	Years	Months	Days	If less than one day
	69	10	21	... hrs. ... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Insurance
11. Industry or business
FATHER 12. Name E. Louis O'Donnell
13. Birthplace Baltimore Md
MOTHER 14. Maiden name Carolina Johnson
15. Birthplace Baltimore Md
16. Informant Edmond H. O'Donnell
Address Ruxton Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 1, 1946 (month) (day) (year)
Cemetery or crematory Greenmount Cemetery
Location Baltimore Md
18. Funeral director Henry W. Jenkins & Son Co
Address McCulloh & Orchard Sts.
19 8-1 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1946, at 10:15 P M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4, 1946, to July 30 1946, and that I last saw him alive on July 30, 1946.

Immediate cause of death	DURATION
Myocardial decompensation	2 yr.
Due to Arterio-sclerosis	
Due to & Chronic nephritis	[illegible]
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [signature] - M.D. (M. D. or other)
Address Towson-4-Md Date signed 7/31/46

M I T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

* 66800

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or towo limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or towo limits, write RURAL and give nearest town)
Street No. 1 Sanford Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ella Peters

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W.

6.(b) Name of husband or wife August J.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 12 1866

8. AGE: Years 80 | Months | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name August Schotta
13. Birthplace Not Known

MOTHER
14. Maiden name Sarah Mellor
15. Birthplace Maryland

16. Informant Roland Peters
Address Catonsville Md

17. Burial Date thereof 7-29-46
(Burial, cremation, or removal. Which?) (mooth) (day) (year)

Cemetery or crematory St. John's
Location Ellicott City Md

18. Funeral director George A. Farley
Address Catonsville Md

19. 7-28- 1946
(Date rec'd by registrar)
Harry L. Miller
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946, at 6:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1944, to July 26 1946 and that I last saw h- alive on July 25 1946

Immediate cause of death	DURATION
Acute ventricular dilatation	5 min.
Due to Chr. Myocardial Insufficiency	2 1/2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer K. Gallagher M.D.
M. D. or other
Address Catonsville-28, Md. Date signed 7-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

06801

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5600 43rd Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emil Petersen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Irene O. McNamara

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): January 22 1863

8. AGE: Years: 83 Months: 6 Days: 6 If less than one day: ____ hrs. ____ min.

9. Birthplace: Racine Wiconsin (Town, county, and state)

10. Usual occupation: Pressman (retired)

11. Industry or business: Printing

FATHER — 12. Name: James Petersen

FATHER — 13. Birthplace: Denmark

MOTHER — 14. Maiden name: Jensina Oberhauser

MOTHER — 15. Birthplace: Denmark

16. Informant: Hospital records, Spring Grove State Hospital, Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 1946 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetary

Location: Washington D.C.

18. Funeral director: W W Chambers Co

Address: Riverdale, Md.

19. July 29 1946 (registrar) Wm Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28, 1946 19____ at 1:35 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16, 1946 19____ to July 28 19 46 and that I last saw h im alive on July 28, 1946 19____

Immediate cause of death: Acute exacerbation of Chronic myocardial insufficiency — DURATION: 12 hours

Due to: Arteriosclerotic C-V disease — Indef

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Henry C. A. Mead M.D

Henry C. A. Mead, M. D. M. D. or other

Address: Catonsville, 28, Md. Date signed: 7/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

06802 8

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years, 14 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 36 years, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth Petrie (Petry)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

B.(b) Name of husband or wife: George Phillip Petry

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): ~~1867~~ Sept ?, 1867

8. AGE: Years: 78 Months: 10 Days: 9 If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Don't Know

FATHER — 13. Birthplace: Don't Know

MOTHER — 14. Maiden name: Don't Know

MOTHER — 15. Birthplace: Don't Know

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11, 1946 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: Baltimore Md.

18. Funeral director: A. Howard Evans

Address: 1400 S. Charles St. Balto 30 Md.

19. 7/10 1946 A W Hedrick Registrar

(registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1946, at 10:10p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 1910, to July 8 1946

and that I last saw h... or ...alive on July 8 1946

Immediate cause of death: Chronic myocardial insufficiency — DURATION: Indef.

Due to: Generalized arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed 7-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INKING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06803

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
510 Delaware Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 510 Delaware Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Joseph William Phipps

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of ~~husband or~~ wife: Annie Alverta Phipps

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): February 7, 1872

8. AGE: Years	Months	Days	If less than one day
74	5	18	— hrs. — min.

9. Birthplace: Towson Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Contractor - General
11. Industry or business: H. T. Campbell & Sons Co.
FATHER 12. Name: Alfred James Phipps
FATHER 13. Birthplace: England
MOTHER 14. Maiden name: Catherine L. Diber
MOTHER 15. Birthplace: England
18. Informant: Mrs. Vernon Otte
Address: 705 W. Joppa Rd., Towson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 27 1946 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cemetery
Location: Towson, Maryland
18. Funeral director: John Burns' Sons
Address: Towson Maryland
19. July 27, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 10S QUA

20. DATE OF DEATH: July 25, 1946, at ~~12~~ P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936 to 25 July 1946 and that I last saw h. alive on 24 July 1946

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Arteria sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Allison, M. D. or other
Address: 4 Burbleigh Ln. Towson 4 Date signed: 26 July 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 668013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 3 mos. 1 day.

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 yr. 3 mos. 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Pilligsley

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME JOSEPH PICKERAL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Florence (Pickeral) Atchison

6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): 7-30-08

8. AGE:

Years	Months	Days	If less than one day
37	11	6	— hrs. — min.

9. Birthplace: ACCOKEEK MARYLAND (Town, county, and state)

10. Usual occupation: farmer

11. Industry or business: farming

FATHER 12. Name: WM. EDWARD PICKERAL

FATHER 13. Birthplace: CHAS. COUNTY MD.

MOTHER 14. Maiden name: MARJORIE COOMBS

MOTHER 15. Birthplace: CHAS COUNTY MD.

16. Informant: Hospital Records

Address: Catonsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-9-46 (month) (day) (year)

Cemetery or crematory:

Location: Piscataway Md

18. Funeral director: Hunt & Rogers

Address: Waldorf Md.

19. 7-8 1946 (Signature of registrar) Harry D. Zuller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6, 1946, at 11:42 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 1945, to July 6, 1946

and that I last saw h...m alive on July 6, 1946

Immediate cause of death	DURATION
Acute cardiac dilitation	3 hours
Pulmonary Edema	
Due to: Chronic Rheumatic Heart Disease	Indefinite
Due to:	
Other conditions: Mental Defective & Psychosis	1 year +

(Include pregnancy within 3 months of death)

Major findings of operation: none

Date of op.:

Autopsy results: confirm the above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Andrew Funk, M.D. (M. D. or other)

Address: Spring Grove State Hosp. Date signed: July 6 1946

Catonsville 28, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47a)

CERTIFICATE OF DEATH

06805 7/31

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Balto.

City or town Hebbville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

7014 Windsor Mill Rd.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County .....

City or town Philadelphia

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3033 N. Broad St.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME HENRY WILLIAM PIEL

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Ellen Virginia Piel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1881

8. AGE: Years	Months	Days	If less than one day
64	9	15	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Cloth Weaver

11. Industry or business Looms, Limited Co.

FATHER 12. Name August Piel

13. Birthplace Balto., Md.

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Mr. Edward L. Oursler

Address 7014 Windsor Mill Rd.

17. Burial Removal (Burial, cremation, or removal. Which?) Date thereof 7/15/46 (month) (day) (year)

Cemetery or crematory Magnolia

Location Phila., Pa.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 7/14/ (Date rec'd by registrar) 1946 Wm E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1946, at 5:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to July 14 1946, and that I last saw him alive on July 13 1946.

Immediate cause of death	DURATION
Carcinoma of Larynx	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm E. Martin M. D. or other

Address Randallstown Date signed 7/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 1680637

1. PLACE OF DEATH:
County: Balto. Md
City or town: Dulaney Valley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Thornick P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Tilghman Goldsborough Pitts

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Dorothy McC. Paine
6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): March 10th 1884

8. AGE: Years	Months	Days	If less than one day
62	4	13	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Insurance
11. Industry or business: Retail
FATHER 12. Name: Sullivan Pitts
FATHER 13. Birthplace: Baltimore Md
MOTHER 14. Maiden name: Ellen Lloyd Goldsborough
MOTHER 15. Birthplace: Dorchester Co Md
16. Informant: Clinton P. Pitts
Address: Dulaney Valley Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25, 1946 (month) (day) (year)
Cemetery or crematory: Green Mount
Location: Balto Md
18. Funeral director: Henry W. Jenkins Sons
Address: McCulloh & Richardson
19. July 25 1946 (Date rec'd by registrar) Upperco Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23. 1946 at 9:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1946 to July 23 1946 and that I last saw him alive on July 23, 1946.

Immediate cause of death	DURATION
Coronary Occlusion	7 hours.
Due to: Arteriosclerosis	unk.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. S. Green Jr. M.D.
M. D. or other
Address: Lawson-4-unk Date signed 7/24/46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. John S. Green
Allegheny and Towson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176a)

CERTIFICATE OF DEATH

BC R

06807

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 Rock Glen Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Alice Frances Price

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 8, 1858

8. AGE: Years: 87 | Months: 10 | Days: 24 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None (Retired School teacher)

11. Industry or business: Unknown

FATHER — 12. Name: Wm T. Price

FATHER — 13. Birthplace: D. C.

MOTHER — 14. Maiden name: Josephine A. Marshall

MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Hospital Records

Address: Catonsville, 28 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/9/46 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 7-8-46 (Date received by registrar) 19____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 19 46 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 20 19 46 to July 19____

and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Broncho - Pneumonia	2 da.
Due to: Hypertensive C-V. Disease	Indefinate
Due to: Senile Psychosis	Indef.
Due to: Fracture of neck of Rt Femur	4 hrs.
Due to: Lumbar Arthritis	1 yr.
Other conditions: Bed Sore over Sacrum	Indefinite

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Mar. 15 '46

Where did injury occur? Home - Balto City (City or town) Md. (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Tripped on rug Injured at work? No.

23. SIGNATURE: Dr. D. L. Caples med. exam. M. D. or other

Address: Reisterstown, Md. Date signed: July 7 '46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

(S) 06808

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Spring Convalescent Home

How long in hospital or institution? 6 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Melvin (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John R. Price

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Annabella (nee Robison)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 1856

8. AGE:

Years	Months	Days	If less than one day
90			..... hrs. ..... min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Wm. Price

FATHER — 13. Birthplace: Balto. Co. Md.

MOTHER — 14. Maiden name: Anna Green

MOTHER — 15. Birthplace: Balto. Co. Md.

16. Informant: Landon M. Brooks

Address: Sparks Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24 1946 (month) (day) (year)

Cemetery or crematory: Chestnut Grove

Location: Balto. Co. Md

18. Funeral director: Landon M. Brooks

Address: Sparks Md.

19. 7-23-1946 (Date rec'd by registrar) Harry D. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 July 1946 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 18 July 1946 to 22 July 1946

and that I last saw h. alive on 18 July 1946

Immediate cause of death	DURATION
Broncho pneumonia	4 days
Due to: Chronic passive congestion	?
Due to: Arteriosclerosis, generalized and cerebral	?
Other conditions: Arthritis, atrophy left arm & leg	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Stephen Lee Magness MD (M. D. or other)

Address: 752 Frederick Ave Date signed: 22 July

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

06869

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25a)

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? two days
Hospital, institution, or street address where death occurred:
Veterans Administration Hos., Fort Howard, Md.
How long in hospital or institution? two days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1814 N. Charles Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW II

3.(a) FULL NAME: HIRAM M. RECKARD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Divorced
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-21-05

8. AGE: Years	Months	Days	If less than one day
41	6	3	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business: Unemployed

FATHER
12. Name: Hiram L.
13. Birthplace: Mass.

MOTHER
14. Maiden name: Catherine Norris
15. Birthplace: Baltimore, Maryland

16. Informant: Clinical Records, Vets. Adm. Hospital
Address: Fort Howard, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) 7/17/46
Cemetery or crematory: Parkview Cem.
Location: Parkville - Balto Co.

18. Funeral director: Wm. Cook Inc
Address: 1212 St Paul St

19. (Date rec'd by registrar) July 15 19 46 Registrar: Mrs Frederick Pearce

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 19 46 at 8:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1946 to July 14 19 46 and that I last saw him alive on July 14 19 46

Immediate cause of death: ACUTE YELLOW ATROPHY OF LIVER — DURATION: 2 wks.
Due to: Chronic nutritional deficiency — unknown
Due to: .....
Other conditions: Jaundice, anemia, purpura
(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: Acute yellow atrophy of liver
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
ROBERT M. CULLISON, M.D. CLIN. DIR. M.D. or other
Address: Fort Howard, Md. Date signed: 7/14/46

VS A15 9-45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 13 — 068138

1. PLACE OF DEATH:
County: Baltimore
City or town: Mt. Washington (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Mt. Washington (If outside city or town limits, write RURAL and give nearest town)
Street No.: 6070 Falls Road (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Margaret Rehbein

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Alfred P. Rehbein
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): August 24-1880

8. AGE: Years: 65 | Months: 10 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Baltimore Co. Maryland (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:
FATHER 12. Name: Jacob Stillhorne
13. Birthplace: Maryland
MOTHER 14. Maiden name: Josephine Stauffer
15. Birthplace: Ohio
16. Informant: Alfred P. Rehbein
Address: 6070 Falls Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 8-1946 (month) (day) (year)
Cemetery or crematory: Poplar
Location: Warren, Baltimore Co. Md.
18. Funeral director: Burgee Funeral Home
Address: 3631 Falls Road
19. 7-8-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7, 1946, at 4:10 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1, 1946, to July 4, 1946 and that I last saw h.e.r. alive on July 4, 1946

	DURATION
Immediate cause of death: Respiratory Failure	2 weeks
Due to: Chronic Cardiac decompensation	3 Months
Due to: Hypertension	15 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Charles F. O'Donnell M.D. M. D. or other
Address: 7301 York Rd. Date signed: July 8, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 — 9-45-15

Dr. Chas. F. O'Donnell
7301 York Road
Towson 768

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

CERTIFICATE OF DEATH

07466 P

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
172 Riverside Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 172 Riverside Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Julius Rehberger, **3.(b) Social Security Number** 213-09-2406

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	married

6.(b) Name of husband or wife Eva I. Schade
6.(c) If alive, give age 35 years
7. Birth date of deceased (mo., day, yr.) Mar 15 1915.

8. AGE: Years	Months	Days	If less than one day
31	4	2	....hrs. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Machinist
11. Industry or business
FATHER 12. Name Harry Rehberger
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden name Margaret Nelson
15. Birthplace Norway.
16. Informant Harry Rehberger.
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/46 (month) (day) (year)
Cemetery or crematory Oak Lawn Cemetery
Location
18. Funeral director Clarence E. Hoffmann
Address 1639 N. Broadway
19. 7-15 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1946, at 12:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Strangulation by hanging,	Immediate
Due to Suicidal.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicidal. Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury Injured at work?

23. SIGNATURE J. M. Carmine M.D.
M. D. or other
Deputy Medical Examiner
Address Baltimore Md. Date signed 7/15/1946

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 54 — 1571 — 06811

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Orville Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jane Yvette Rose

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Joseph Walter Rose
6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) July 26 - 1917

8. AGE: Years	Months	Days	If less than one day
28	11	16	hrs. min.

9. Birthplace Indiana (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Harry J. Clouse
13. Birthplace Indiana

MOTHER
14. Maiden name Tressa May Hull
15. Birthplace Indiana

16. Informant Joseph W. Rose
Address 11 Orville Rd. M.R. 21

17. Trans. (Burial, cremation, or removal. Which?) Date thereof July 13-46 (month) (day) (year)
Cemetery or crematory Auburn
Location Indiana

18. Funeral director John G. Connelly
Address 418 Eastern Ave. Essex

19. July 13 1946 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1946, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 1946, to July 12 1946 and that I last saw h.. alive on July 12 1946

Immediate cause of death	DURATION
Tumor of Cerebellum,	3 mo
Due to Malignant. ovary,	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations no
Date of op.
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James F. White M.D.
M. D. or other
Address 7601 Eastern Ave Baltimore 24, Md. Date signed 7/15/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15

COPY SENT TO LOCAL REGISTRAR No. ____ DATE 7/23/46

ROSENBERG.—Suddenly, on July 8, 1946, HENRY, beloved husband of Martha Rosenberg and devoted father of Lucille and Ronald Rosenberg, brother of Raphael Rosenberg and Mrs. Sadie Harris.
Services from the Ahrens Funeral Home, 2432 Reisterstown road, on Wednesday, July 10, at 3 P. M. Interment in Oheb Shalom Cemetery. [Please omit flowers.] In mourning at 1705 North Bentalou street. 10c

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

06812

Reg. Diat. No.

County Baltimore

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Evergreen Park #8 Off Pulaski Highway Rd.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto Co.

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3300 Shuck St. (If rural, give LOCATION) (Canton)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Rosenberg.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Martha Rosenberg

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feby 14/1882

8. AGE: Years 64 | Months 4 | Days 24 | If less than one day ... hrs. ... min.

9. Birthplace San Francisco Cal (Town, county, and state)

10. Usual occupation Furniture Salesman

11. Industry or business

FATHER
12. Name Samuel Rosenberg
13. Birthplace New York City

MOTHER
14. Maiden name Eva Wolf
15. Birthplace Germany

16. Informant Mrs. Martha Rosenberg
Address 3300 Shuck St. Canton

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10 46 (month) (day) (year)

Cemetery or crematory Oheb Shalom Cemetery

Location O'Donnell St

18. Funeral director J. Ahrens & Co

Address 2432 Reisterstown Rd

19. July 9 19 46 (Date rec'd by registrar) Alex Hedrick per oak Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1946, at 1.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	Immediate
Due to	
Due to Hypertension	7
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE W M Barmine M.D. (M.D. or other)

Address Deputy Medical Examiner Date signed 7/8/46

UNDER SHALOM CEMETERY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age and cause of death are important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

06813 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(13F)

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.
How long in hospital or institution? 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 724 S. Charles St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: JOSEPH J. RUFFIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Anna Ruffin
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): 9-12-02

8. AGE: Years	Months	Days	If less than one day
43	10	4	....hrs. ....min.

9. Birthplace: Portsmouth, Va.
(Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business:

FATHER
12. Name: Joseph Ruffin
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary ?
15. Birthplace: Unknown

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 - 21 - 46 (month) (day) (year)
Cemetery or crematory: Balt. National
Location:
18. Funeral director: James A. Dawson
Address: 1142 Wolfe St

19. July 15 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1946 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1946 to July 16, 1946 and that I last saw him alive on July 16, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis:	7 months Plus
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of Injury: Injured at work?

23. SIGNATURE: Jacob F. Yates M.D.
M. D. or other
Address: Vet. Hosp. Ft. Howard Md. Date signed: July 16 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06814

Reg. Dist. No. 43

1. PLACE OF DEATH:
County: Baltimore
City or town: Baltimore, 6, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Baltimore (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 32-A Oak Grove Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary L Ruhl

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Homer Ruhl
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 12, 1903

8. AGE: Years 43 | Months 7 | Days 10 | If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER 12. Name: Chas Holtzinger
13. Birthplace: Penna

MOTHER 14. Maiden name: Emma Cramer
15. Birthplace: Penna

16. Informant: Mr Homer Ruhl
Address: 32a Oak Grove Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/26/46 (month) (day) (year)
Cemetery or crematory: Balto Nat'l
Location: Balto

18. Funeral director: Lanahan Funeral Home
Address: 7401 Belair Rd Balto 6 Md.

19. July 24 19 (Date rec'd by registrar) Mrs O. L. Reisinger Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 19 46 at 8 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 29 19 46, to July 22 19 46
and that I last saw her alive on July 22 19 46

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Coronary atherosclerosis	1 yea
Due to: Hypertensive C-V disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A L Kolodny, M.D. M. D. or other
Address: Ridge Rd. Baltimore, 6, Md. Date signed: July 22, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Fuller

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

06815 P

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto.
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred Home
How long in hospital or institution? 1 yr.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County .....
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
Street No. Ridgely Ave (If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Emma K. Rupprecht. **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Oct. 19, 1879

8. AGE: Years	Months	Days	If less than one day
66	8	14	..... hrs. ..... min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual occupation Teacher
11. Industry or business .....

FATHER
12. Name Christian Rupprecht
13. Birthplace Germany

MOTHER
14. Maiden name Barbara Fisher
15. Birthplace Germany

16. Informant Miss Mary Rice
Address 2952 Ridg. Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6, 46 (month) (day) (year)
Cemetery or crematory Immanuel Cem
Location Gunpowder Road (City)
18. Funeral director L. HEEMANN & SON
Address 32 S. BROADWAY.
19. 7/6 19 46 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 19 46 at 12 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 46 to 7/3/46 19
and that I last saw h er alive on 7/3/46 19

Immediate cause of death	DURATION
Abcess of Lung	2 wks
Due to Hemiplegia & arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Zach. R. Morgan M. D. or other
Address 6E-Read St. Date signed 7/6/46

3 Kingsley Road

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

8

Reg. Dist. No. 06816 41

1. PLACE OF DEATH: Balto. Co.
County Dundalk, Maryland
City or town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2614 Liberty Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Michael Ruth

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Bertha Ruth
6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) March 27, 1890

8. AGE: Years	Months	Days	If less than one day
56	3	26	hrs. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Continental Can Co.
11. Industry or business
FATHER 12. Name Jacob Ruth
13. Birthplace Baltimore, Maryland
MOTHER 14. Maiden name Mollie Harbick
15. Birthplace Baltimore, Maryland
16. Informant Mrs Bertha Ruth
Address 2614 Liberty Parkway
17. Burial Date thereof 7/27/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Eastern Avenue
18. Funeral director John C. Miller Funeral
Address 2435 E. Olive St.
19. 7/25 19 46 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24th 1946 at 5:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1946 to July 24 1946
and that I last saw him alive on July 24 1946.

Immediate cause of death	DURATION
Cardiac Accident.	2 hrs.
Due to Hypertensive C.V.-R. Disease	
Due to	
Other conditions Cardiac Accident	July 24th

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. D. Davis M.D.
M. D. or other
Address Dundalk - Md. Date signed 7/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 06817 4

1. PLACE OF DEATH:
County: Balto Co.
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto. Co.
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 324 Stillwaters Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: August Saccatti Sacilotto

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 29/1907

8. AGE: Years: 39 Months: 1 Days: 9 If less than one day: hrs. min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: Shipfitter
11. Industry or business: Bethelem Steel Co.

FATHER
12. Name: Louis V. Sacilotto
13. Birthplace: Italy

MOTHER
14. Maiden name: Amelia A Bittiol
15. Birthplace: Italy

16. Informant: Louis V. Sacilotto
Address: 322 Aberle Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 12/1946 (month) (day) (year)
Cemetery or crematory: Oaklawn
Location: Baltimore Md
18. Funeral director: Harry N. Arwood
Address: 4204 Ridgewood Ave

19. 7/10 1946 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1946, at 1 06 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Fractured Skull	10 min.
Due to: Fall from Stageway in	
Due to: B.S. Shipyard.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 7-8-46
Where did injury occur? Balt. H. Shipyard Spl. Baltimore
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Work
Means of injury: Fell from Stageway Injured at work? Yes

23. SIGNATURE: W B Davis M.D. M. D. or Other
Address: Sparrows Point Md. Date signed: 7-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(13) (1*) 06818

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 6 mos., 9 days

Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 6 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 81 West Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Edward J. Sanford

3.(b) Social Security Number: 215-01-6231

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gladys Sanford

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): February 17, 1910

8. AGE:	Years	Months	Days	If less than one day
	36	5	5	...hrs. ...min.

9. Birthplace: Solomon's Island, Maryland (Town, county, and state)

10. Usual occupation: Steward

11. Industry or business:

FATHER 12. Name: Irvin C. Sanford

13. Birthplace: Virginia

MOTHER 14. Maiden name: Lottie Schneider

15. Birthplace: Baltimore, Maryland

16. Informant: Edward J. Sanford

Address: 81 West St., Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25, 1946 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: 4300 Old Frederick Rd., Balto., Md.

18. Funeral director: Frank Newell

Address: Reisterstown, Rd., Pikesville, Md.

19. July 22, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22, 1946 at 10:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13, 1946 to July 22, 1946 and that I last saw him alive on July 22, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart L Shaffer M. D. M. D. or other

Address: Mount Wilson, Md. Date signed: 7/22/46

Rec'd 7-24-46 Dr. E. E. Nichols - mw

M

06819

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville, Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville, Md (If outside city or town limits, write RURAL and give nearest town)
Street No. 15 N. Rolling Road (If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Anna D. Schaaf
3.(b) Social Security Number

4. Sex: Female
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: M
6.(b) Name of husband or wife: Chas Schaaf
6.(c) If alive, give age ___ years
7. Birth date of deceased (mo., day, yr.): Aug 31st 1868
8. AGE: Years 77 Months 11 Days 27 If less than one day ___ hrs. ___ min.
9. Birthplace: Germany (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: Conrad Meuser
13. Birthplace: Germany
MOTHER 14. Maiden name
15. Birthplace: Germany
16. Informant: Anna Bleecker
Address: 15 N. Rolling Rd
17. Burial (Burial, cremation, or removal? Which?) Date thereof 7/31/46 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md
18. Funeral director: F. A. Weippert & Son
Address: 300 Eutaw Place
19. 7-30 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28, 1946, at 10:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 11, 1946, to July 25 1946,
and that I last saw h... alive on July 25th 1946

Immediate cause of death: Cessation of body function
Due to: Generalized Metastasis
Due to: Carcinoma of breast — DURATION: 1 year
Other conditions: Mastectomy in February 1946 (Include pregnancy within 3 months of death)
Major findings of operations: Scirrhous Carcinoma (SCIRRHOUS) Date of op. Feb. 46
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ___ Date of ___
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ___ Injured at work?

23. SIGNATURE [signature] M. D. or other
Address: 116 Catherine St. Date signed 7-29-46

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06820 Reg. Dist. No. 42

1. PLACE OF DEATH:

County Balto.

City or town Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

3024 Putty Hill Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3024 Putty Hill Ave

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME John Albert Schneider

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Amelia Schneider

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1/9/75

8. AGE: Years	Months	Days	If less than one day
71	6	24	..... hrs. ..... min.

9. Birthplace Balto. Co. Md.

(Town, county, and state)

10. Usual occupation Truck farmer

11. Industry or business

FATHER

12. Name John Schneider

13. Birthplace

MOTHER

14. Maiden name Katherine Hoffstetter

15. Birthplace Balto. Co. Md.

16. Informant Mrs. A. Schneider

Address 3024 Putty Hill Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 28 46 (month) (day) (year)

Cemetery or crematory St Johns Luth.

Location Balto. Co. Md.

18. Funeral director Lanahan Funeral Home

Address 7401 Belair Rd.

19. July 26 1946 Mrs. A. L. Reifsnyder

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25th 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1946, to July 25 1946 and that I last saw h... alive on July 25 1946

Immediate cause of death	DURATION
Coronary Thrombosis	10 minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Edgar Weiss, M.D.

M. D. or other

Address 6232 Belair Road Date signed July 26, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15—9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

06821 8

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Halthorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
4511 Rehbaum Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Halthopre
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4511 Rehbaum Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war NO

3.(a) FULL NAME Frank Henry Scholz Sr.

3.(b) Social Security Number 714-10-2544

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ella R. Scholz
6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 1, 1870

8. AGE:	Years	Months	Days	If less than one day
	76	3		..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual occupation Express Man
11. Industry or business Railway Express
FATHER 12. Name Gustav Scholz
13. Birthplace Baltimore Md.
MOTHER 14. Maiden name Mary ?
15. Birthplace Germany
16. Informant Ella R. Scholz
Address 4511 Rehbaum Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/4/46 (month) (day) (year)
Cemetery or crematory Loudon Park
Location Baltimore Md.
18. Funeral director Geo. W. Little
Address 2700 Edmondson Ave.
19. 7-1-46 (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1/46 19..... at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46, to July 1 19 46 and that I last saw h.. alive on July 1 19 46

Immediate cause of death	DURATION
Myocarditis	3 hrs
Decompensation	
Due to Arteriosclerosis	1 yr
Due to arterial hypertension?	
Other conditions Ch Arthritis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE G B Brumbaugh M. D. or other
Address Elkridge Md Date signed 7/1/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

06822

Reg. Dist. No. 35

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural near Freeland. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rural near Freeland. (If outside city or town limits, write RURAL and give nearest town)

Street No. 5 mi. S.W. of Freeland (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Romaine Arlene Shaffer.

3. (b) Social Security Number: 189-07-0638.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Larnid V. Shaffer.

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): July 31, 1918.

8. AGE:

Years	Months	Days	If less than one day
27	11	9	hrs. min.

9. Birthplace: Brodbecks Penna (Town, county, and state)

10. Usual occupation: Packer

11. Industry or business: Shoe factory.

FATHER — 12. Name: Clayton Taylor.

FATHER — 13. Birthplace: Glenville, Pa.

MOTHER — 14. Maiden name: Lucinda Thoman.

MOTHER — 15. Birthplace: Brodbecks, Pa.

16. Informant: Larnid Shaffer

Address: Freeland, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 12, 1946 (month) (day) (year)

Cemetery or crematory: Stiltz Cemetery

Location: Glen Rock, Pa. R.D.

18. Funeral director: Jacob Harbaugh

Address: New Freedom Pa.

19. July 10 1946 (Date rec'd by registrar) Edwin L. Preston Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9, 1946, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1946, to July 9 1946

and that I last saw h... alive on July 9 1946

Immediate cause of death: Carcinoma of breast with metastasis to lung & liver — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: G. W. Frame M. D. or other

Address: Parkton, Md. Date signed: 7/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-B)

CERTIFICATE OF DEATH

06823

Reg. Dist. No. 4

8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, institution, or street address where death occurred:

Veterans Administration, Fort Howard, Md.

How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 132 S. Washington Street

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME

SHERPINSKI, Steve

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): 11/28/17

8. AGE: Years	Months	Days	If less than one day
28	8	0	...hrs. ...min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Deceased

13. Birthplace

MOTHER 14. Maiden name: Mrs. Pheobe Sherpinski

15. Birthplace: Deceased

16. Informant: Clinical Records, Veterans Adm.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31/46 (month) (day) (year)

Cemetery or crematory: Harvard Heart

Location: Baltimore

18. Funeral director: Fred W. Ozazewski

Address: 1930 Eastern Ave. Baltimore, Md.

19. 7-30 1946 [signature] Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19 46 at 9:28 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3, 19 46, to July 19 46

and that I last saw him alive on July 28 19 46

Immediate cause of death	DURATION
CEREBRAL EMBOLISM WITH RIGHT HEMAPLEGIA	27 hrs.
Due to HEART DISEASE; ARTERIO SCLEROSIS; MITRAL STENOSIS AND INSUFFICIENCY;	3 months plus
Due to AURICULAR FIBRILLATION; MYOCARDIAL INSUFFICIENCY.	
Other conditions	

(Incidote pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Allison M. D. or other

ROBERT M. ALLISON, M.D.

Address: V.A.H., FORT HOWARD, MD. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57-d

06824

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: Deer Park Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: (Rural) Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: George Russell Shipe

3.(b) Social Security Number: 232-01-8106

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Valley Russell Shittington
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): April 23, 1890

8. AGE: Years	Months	Days	If less than one day
56	2	10	hrs. min.

9. Birthplace: Shenandoah County, Virginia (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Contractor

FATHER
12. Name: Robert Lorenzo Shipe
13. Birthplace: Shenandoah County, Virginia

MOTHER
14. Maiden name: Mary Catherine Pinkey
15. Birthplace: Shenandoah County, Va.

16. Informant: Mrs. George R. Shipe
Address: Deer Park Road, Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 5 1946 (month) (day) (year)
Cemetery or crematory: Edgehill Cemetery
Location: Charles Town, West Va.

18. Funeral director: Melvin T. Strider
Address: Charles Town, W. Va.

19. 7/3/46 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 1946 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946, to July 3 1946, and that I last saw him alive on July 3 1946.

Immediate cause of death	DURATION
Cerebral tumor	
Not known whether benign or malig-	
Due to: nant. Unqualified. Duration, four	months.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: No autopsy.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other
Address: Randallstown Date signed: 7/3/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

06825

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years, 1 month, 11 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 10 years, 1 month, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1724 Aliceanna Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Roch Siok

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: ?
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1873?

8. AGE: Years	Months	Days	If less than one day
73	?	?	hrs. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: ?

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18, 1946 (month) (day) (year)
Cemetery or crematory: Spring Grove State Hospital
Location: Catonsville 28, Maryland
18. Funeral director: Spring Grove State Hospital
Address: Catonsville 28, Maryland
19. 7—18 1946 Harry D. Miller Deputy Registrar
(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1946, at 6:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1936, to July 6 1946 and that I last saw him alive on July 6 1946

Immediate cause of death	DURATION
Sudden death due to chronic myocarditis	Indefinite
Due to:	
Due to:	
Other conditions: Senile Psychosis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. D. Eagles, M.D. Med. Exam. M. D. or other
Address: Reisterstown, Md. Date signed: July 6 '46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06826

Reg. Dist. No. 32

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 1 mo., 2 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 2 yrs., 1 mo., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 16 E. Hamburg Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George H. Slater, Jr.

3.(b) Social Security Number: 168-01-7648

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marion Slater

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): December 17, 1911

8. AGE: Years	Months	Days	If less than one day
34	6	14	..... hrs. ..... min.

9. Birthplace: Butler, Pennsylvania (Town, county, and state)

10. Usual occupation: Body & Fender Man (Garage)

11. Industry or business:

FATHER — 12. Name: George H. Slater

13. Birthplace: Butler, Pennsylvania

MOTHER — 14. Maiden name: Alice Fleeger

15. Birthplace: Butler, Pennsylvania

16. Informant: George H. Slater, Jr.

Address: 16 E. Hamburg St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 3, 1946 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: 3801 Frederick Road, Balto., Md.

18. Funeral director: John R. Kenny

Address: 1242 Leeds Terrace, Arbutus, Md.

19. July, 1, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1946 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29, 1944 to July 1, 1946 and that I last saw him alive on July 1, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs. 3 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Fatal Pulmonary Hemorrhage	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S Shoffer M.D. (M. D. or other)

Address: Mount Wilson, Md. Date signed: 7/1/46

Rec'd - 7-3-46 Dr Nichols

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

06827

CERTIFICATE OF DEATH

Reg. Dist. No. 461

1. PLACE OF DEATH:
County: BALTIMORE
City or town: DUNDALK – (TURNERS) ST V
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore (Baltimore)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5709 Cardinal Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME FRANK WHITFIELD SMALL.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 27, 1933

8. AGE: Years	Months	Days	If less than one day
13	6	22	hrs. min.

9. Birthplace: Kingstreet, S. C. (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Frank Whitfield
13. Birthplace: S. C.

MOTHER
14. Maiden name: Maggie Fulton
15. Birthplace: S. C.

16. Informant: Cephus Small
Address: 5709 Cardinal Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-23-46 (month) (day) (year)
Cemetery or crematory
Location: Kingstreet S. C.
18. Funeral director: Daisy L. Rogers
Address: Kingstreet, S. C.

19. 7/20 19 46 (Date rec'd by registrar)
Miriam Whumbs Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-19-46 19 at 150 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
DROWNING	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 7-19-46
Where did injury occur? Dundalk – Balto Md.
(City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) Public Place
Means of injury Dived into water & failed to come up Injured at work?

23. SIGNATURE J. B. Davis M.D.
Address Dundalk – Balto Co. Md. M.D. or other
Date signed 7-20-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

06828 B

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Towson Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Emily Louise Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 29 - 1944

8. AGE: Years 2 | Months 5 | Days 9 | If less than one day hrs. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Matthew Smith
13. Birthplace Towson. Md.

MOTHER 14. Maiden name Catherine Smith
15. Birthplace Leonard Town Md.

16. Informant Catherine Smith
Address 9 Prospect Hill Towson Md.

17. (Burial, cremation, or removal. Which?) Date thereof 7-9-46 (month) (day) (year)
Cemetery or crematory Pleasant Rest Cemetery
Location Towson Md Balto Co.

18. Funeral director Archibald A. Gaddis
Address 2101 N. Caroline St. Balto. Md.

19. 7-9 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1946, at 3 15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946, to 1946
and that I last saw h alive on 1946

Immediate cause of death	DURATION
Suffocation in burning building	7/8/46
Due to	
Due to	
Other conditions 4th degree burns head, extremities, body (Include pregnancy within 3 months of death)	7/8/46

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Fire-accidental Date of 7/8/46
Where did injury occur? Towson (City or town) Baltimore (County) Md. (State)
Injured at home, farm, industry, public place (where?) Boarding house
Means of injury Fire-cause undetermined Injured at work? no

23. SIGNATURE Bolling Hudson M.D., D.M.E.
M. D. or other
Address Towson Md Date signed 7/8/46.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98-2)

CERTIFICATE OF DEATH

06829

Reg. Diat. No. 35

P

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, Institution, or street address where death occurred:

York Road

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rural Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: York Road

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: Louisa M. Smith

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ### Capt. James A. Smith

6.(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.): August 11, 1853

8. AGE:

Years	Months	Days	If less than one day
92	11	19	--- hrs. --- min.

9. Birthplace: Frederick, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Ignatius Hagan

13. Birthplace: Not obtainable

MOTHER

14. Maiden name: Mary McMahon

15. Birthplace: Ireland

16. Informant: Mrs. Mary Louise Rudigier

Address: York Road, Towson

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/1/46 (month) (day) (year)

Cemetery ###### New Cathedral

Location: Baltimore, Md.

18. Funeral director: H. H. Mears & Son

Address: 805 N. Calvert St.

19. 7-31 (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1946 at 2:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to July 29 1946

and that I last saw h.e.r. alive on July 29 1946

Immediate cause of death: Carcinoma Faciei

DURATION: 72 Hrs.

Due to: Chronic pneumonia 2 WKS.

Due to: Myocardial failure of old age

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charles F. O'Donnell M. D. or other

Address: 7301 York Rd. Date signed 7/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

P 06830

Reg. Dist. No. 42

1. PLACE OF DEATH:
County Baltimore
City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1267 Stevens Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clara R. Snyder. **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife Franklin B. Snyder. 6.(c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 30 April 1862.

8. AGE: Years 84 | Months 2 | Days 13 | If less than one day ___ hrs. ___ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation House wife

11. Industry or business At Home

FATHER 12. Name Conrad Helwig

13. Birthplace Germany

MOTHER 14. Maiden name ?

15. Birthplace Germany

16. Informant Mr. Joseph Snyder

Address 1267 Stevens Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 16 July 46 (month) (day) (year)

Cemetery or crematory St. Paul's Cemetery

Location Violetsville - Md.

18. Funeral director F. B. Shubert & Son

Address 1300 Eutaw Place.

19. 7-16 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 - 1946, at 11:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24 1945 to July 13 1946 and that I last saw her alive on July 13 1946

Immediate cause of death	DURATION
Cardio-Vascular Degenerative Disease	18 Yrs.
Due to	
Due to	
Other conditions Acute Pulmonary Edema	20 Minutes

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Earl Cass, M.D. M. D. or other

Address 1001 Wickes Ave Date signed 7-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

06831 P

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Balto

City or town Arbutus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1315 Poplar Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ruth Edith Somerville

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Francis M Somerville 6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1900

8. AGE:	Years	Months	Days	If less than one day
	45	8	4	...hrs. ...min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name B. Tribull

13. Birthplace Md

MOTHER 14. Maiden name Anne Mackard

15. Birthplace Md

16. Informant Francis M Somerville

Address 1315 Poplar ave Arbutus Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-18-46 (month) (day) (year)

Cemetery or crematory London Park

Locafion Baltimore Md.

18. Funeral director J.C. Hig-inbotham

Address Elliott City Md

19. 7-17 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 - 1946 at 7 45 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to July 15 1946

and that I last saw her alive on July 12 1946

Immediate cause of death Carcinoma of Breast — DURATION 13 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J W Larson M.D. M. D. or other

Address Hebbville Md Date signed 7/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

06832

2411 N. Charles St., Baltimore (93-0)

CERTIFICATE OF DEATH

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING.

VS A15 9-45-15

1. PLACE OF DEATH:

County Baltimore

City or town Cockeysville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred: Masonic Home, Cockeysville Md

How long in hospital or institution? 5 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County

City or town Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5303 Ethelbert Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Robert Alexander Spence

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary Martha Spence

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1867

8. AGE: Years	Months	Days	If less than one day
78	6	20	..... hrs. ..... min.

9. Birthplace Orangeville, Ontario, Canada (Town, county and state)

10. Usual occupation Landscape Gardner

11. Industry or business

FATHER 12. Name Adam Spence

FATHER 13. Birthplace Canada

MOTHER 14. Maiden name Mary Cussy

MOTHER 15. Birthplace Canada

16. Informant Laura M. Schroeder

Address Masonic Home, Cockeysville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/9/46 (month) (day) (year)

Cemetery or crematory Stone Chapel, Pikesville Md

Location

18. Funeral director Wm. Cook

Address St. Paul & Preston St.

19. 7/6 1946 L.M. Schroeder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1946, at 1:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1941 to July 5 1946 and that I last saw him alive on July 4 1946

Immediate cause of death	DURATION
Coronary Occlusion with Thrombosis	1 day
Due to Hypertensive Cardio-Vascular Disease	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wilbur F. Skellman M. D. or other

Address 6 E. Biddle St Date signed 7/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

16833 P

Reg. Dist. No. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Dundalk 22 Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 121 Main St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Dundalk 22 Md (If outside city or town limits, write RURAL NEAR and give town) Ward No.

Street No. 121 Main St (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Clarence Stathens

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Estella

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1895

8. AGE: Years 50 | Months | Days | If less than one day hrs. min.

9. Birthplace Approximately Co Va (town, county, and state)

10. Usual occupation Laborer

11. Industry or business Bethlehem Steel Co.

FATHER 12. Name Patrick Stathens

13. Birthplace Va

MOTHER 14. Maiden name Martha Sue Morgan

15. Birthplace Va.

16. Informant Estella Stathens

Address 121 Main St

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 16/46 (month) (day) (year)

Cemetery or crematory

Location Approximately Co Va

18. Funeral director Mr. Robert G. Elliott Dept.

Address 1129 N. Caroline St

19. 7-15 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14. 1946, at 12.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1946 to July 14 1946, and that I last saw him alive on July 12 1946.

	DURATION
Immediate cause of death Cerebral Hemorrhage	2½ days
Due to Cardio-Vascular Hypertensive Disease	Two yrs.
Due to —	
Other conditions —	

(Include pregnancy within 8 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dawson L. Harbor M. D. or other

Address Sparrows Point 19 Md Date signed 7/14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

06834

Reg. Dist. No. 33

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Reisterstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Reisterstown (If outside city or town limits, write RURAL and give nearest town)
Street No. 34 Hanover Rd. (If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Harry Merryman Stumpf

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace A. Stumpf
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 26, 1885

8. AGE: Years	Months	Days	If less than one day
61	1	10	..... hrs. ..... min.

9. Birthplace: Balto. Co. (Town, county, and state)
10. Usual occupation: Dentist
11. Industry or business

FATHER
12. Name: Henry Stumpf
13. Birthplace: Balto. Co.

MOTHER
14. Maiden name: Elizabeth Merryman
15. Birthplace: Balto. Co.

16. Informant: Mrs. Elizabeth Osborn
Address: Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9, 1946 (month) (day) (year)
Cemetery or crematory: All-Saints
Location: Reisterstown

18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.

19. 7-8-1946 (Date rec'd by registrar) Harry B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 July 1946, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 June 1946, to 6 July 1946 and that I last saw him alive on 6 July 1946

Immediate cause of death	DURATION
Hypotension Cardiovascular Disease	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Herman F. Eisenberg M.D. M. D. or other
Address: Reisterstown, Md. Date signed: 7 July 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

06835

Reg. Dist. No. 3

1. PLACE OF DEATH:

County: Baltimore

City or town: Rockdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
3615 Marriott Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Rockdale
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3615 Marriott Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Irving Lewis Subock

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary F. Subock

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 15, 1875

8. AGE:	Years	Months	Days	If less than one day
	71	3	3	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired Plasterer

11. Industry or business: Self

FATHER
12. Name: John Subock
13. Birthplace: Germany

MOTHER
14. Maiden name: Josephine Schaible
15. Birthplace: Maryland

16. Informant: Mrs. Mary F. Whitmore
Address: 3615 Marriott Lane, Rockdale

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cemetery

Location: Randallstown, Md.

18. Funeral director: E. W. Lamoreaux

Address: 4510 Liberty Heights Ave.

19. July 30 1946 (Date rec'd by registrar) Henry A. Longo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1946 at 7.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1946 to July 28 1946 and that I last saw him alive on July 27 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 months
Due to: Cerebral & Femoral Arteriosclerosis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. C. Lynch M. D. or other

Address: 4509 Liberty Hgts Ave. Date signed July 29

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

268

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(932)

CERTIFICATE OF DEATH

06836

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

314 Poplar Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 314 Poplar Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Gertrude May Tankersley.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife William

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 29 - 1879

8. AGE: Years	Months	Days	If less than one day
67			____ hrs. ____ min.

9. Birthplace Balto. (Town, county, and state)

10. Usual occupation at Home

11. Industry or business ____

FATHER — 12. Name James L. Saunders

13. Birthplace Virginia

MOTHER — 14. Maiden name Sarah Sidney

15. Birthplace Balto.

16. Informant William Tankersley

Address 314 Poplar Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/31/46 (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Eastern Ave. Balto. Md.

18. Funeral director John G. Connelly

Address 418 Eastern Ave. Essex 21.

19. July 31 1946 John G. Connelly (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1946 at 10:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to July 29 1946 and that I last saw h alive on July 29 1946

Immediate cause of death	DURATION
Chronic Myocarditis	yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. Waters M.D. M. D. or other

Address 7601 Eastern Ave, Baltimore 24, Md. Date signed 7/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

06837

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since July 23, 1909

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? since July 23, 1909

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HARFORD

City or town rural — Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No. rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JULIA TOBIN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife none

8.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1874 —

8. AGE:

Years	Months	Days	If less than one day
72	—	—	— hrs. — min.

9. Birthplace — Maryland (Town, county, and state)

10. Usual occupation housekeeper

11. Industry or business —

FATHER

12. Name unknown

13. Birthplace unknown

MOTHER

14. Maiden name unknown

15. Birthplace unknown

16. Informant Hospital Records

Address Spring Grove State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15 1946 (month) (day) (year)

Cemetery or crematory St. Francis

Location Aberdeen Md.

18. Funeral director Howard K. McComas

Address Aberdeen Md

19. 7-14 1946 Harry L. Mullin Deputy Registrar (registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1946, at 10 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9, 1909 to July 13, 1946 and that I last saw h... alive on July 13 1946

Immediate cause of death	DURATION
Hypostatic Pneumonia	1 week
Due to Arteriosclerosis Generalized	indefinite
Due to	
Other conditions Decubitus ulcers "Paranoid Dementia" since 1909	

(Include pregnancy within 3 months of death)

Major findings of operations no Date of op. —

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Doctor Irwin, M.D. M. D. or other

Address Spring Grove State Hosp. Date signed July 14, 1946

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06838 38
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Rogers Forge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
209 Murdock Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3110 W. North Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HENRY VOLTZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Fannye M. Voltz
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7, 1877

8. AGE: Years	Months	Days	If less than one day
69	0	7	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Plumber
11. Industry or business

FATHER
12. Name: --
13. Birthplace

MOTHER
14. Maiden name: --
15. Birthplace

16. Informant: Mrs. Fannye M. Voltz
Address: 3110 W. North Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/46 (month) (day) (year)
Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 7-16 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13, 1946 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/4 1945, to 7/11 1946
and that I last saw him alive on 7/11 1946

Immediate cause of death	DURATION
Coronary thrombosis	1 week
Due to Arteriosclerotic heart disease	2 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Edward Leach, M. D. or other
Address: 14 E. Eager St. Date signed 7/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (466)

06839

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 5 months, 21 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 1 year, 5 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1803 Hanneman Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James Wagner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	widowed

6.(b) Name of husband or wife: unk.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 26, 1865

8. AGE: Years	Months	Days	If less than one day
80	9	7	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: laboring

FATHER — 12. Name: John Wagner

FATHER — 13. Birthplace: Bohemia

MOTHER — 14. Maiden name: Marianna ?

MOTHER — 15. Birthplace: unk.

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-8-46 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. 7-8- 1946 (Date rec'd by registrar) Harry S. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1946, at 12:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 13 1944, to July 3 1946

and that I last saw him alive on July 3 1946

Immediate cause of death	DURATION
Pulmonary Edema	8 days
Due to: Chronic Myocarditis	Indef.
Due to: Hypertensive Cardiovascular Renal Disease	indef.
Other conditions: Carcinoma of the cardiac end of the stomach	indef.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk

Isadore Tuerk, M.D. M. D. or other

Address: Catonsville 28, Md. Date signed: 7/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1570)

06840

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs. 3 mo. 28 days
Hospital, institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution? 7 yrs. 3 mo. 29 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Fulton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Virginia Walters

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 10, 1937

8. AGE: Years	Months	Days	If less than one day
9	3	9	..... hrs. ..... min.

9. Birthplace: Boston, Mass. (Town, county, and state)
10. Usual occupation: Inmate, Rosewood State Tr. Sch.
11. Industry or business: Owings Mills, Md.

FATHER
12. Name: Gerald Pielke
13. Birthplace: Unknown

MOTHER
14. Maiden name: Virginia Walters
15. Birthplace: Howard Co., Md.

16. Informant: Institutional records; Rosewood
Address: State Training School, Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20-46 (month) (day) (year)
Cemetery or crematory: Rosewood
Location: Balto Co.

18. Funeral director: J. F. Eline and Sons
Address: Reisterstown, Md.

19. 7-20-46 (Date rec'd by registrar) Harry B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1946, at 6:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/21/39 1939 to July 19 1946 and that I last saw her alive on July 19 1946

Immediate cause of death	DURATION
Due to: Congenital Hydrocephalus	Congen.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. None
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: George C. Medairy, M.D. or other
Address: Owings Mills, Md. Date signed 7/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

06841

CERTIFICATE OF DEATH

★ Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years, 8 months, 17 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 18 years, 8 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3401 Bateman Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: Rebecca Wiener

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unk.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years	Months	Days	If less than one day
62			hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home
FATHER 12. Name: unk.
13. Birthplace:
MOTHER 14. Maiden name: unk.
15. Birthplace:
16. Informant: Hospital Records
Address: Catonsville 28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-28-46 (month) (day) (year)
Cemetery or crematory: Rosedale
Location: Phila Rd & Hamilton Ave
18. Funeral director: Jack Lewis Inc
Address: 1439 E Baltimore St
19. 7-28-46 (Date rec'd by registrar) Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1946, at 6:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9 1927, to July 26 1946 and that I last saw her alive on July 26 1946

Immediate cause of death	DURATION
Left lower lobe pneumonia	6 hours
Due to Secondary myocardial insufficiency, chronic	Indef.
Due to Chronic hypertensive arterio-sclerotic cardiovascular disease.	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: pan-hysterectomy, as above.
Date of op. 6/25/46
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, MD. M. D. or other
Address: Catonsville 28, Md. Date signed 6/27/46

VS A15 19-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 30 P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonsville
(c) Hospital or institution: Hood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 N. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Elizabeth Williams

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John T. Williams
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 13, 1868

8. AGE: Years: 77 | Months: 10 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: ? Naumann
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Margaret Casteneda
(b) Address: 90 Pierrepont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-46 (month) (day) (year)
(c) Cemetery or crematory: Mount Olivet
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) 7/29/46 (Date rec'd by registrar) (b) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1946, at 7:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1946 to July 26 1946, and that I last saw h alive on July 25 1946.

Immediate cause of death	Duration
(a) Hypostatic Pneumonia	5 days
(b) Terminal	
Due to (c) Cardio Vascular Renal Disease	14 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliot W. Johnson M. D.
Address 3432 Druid Hill Ave Date signed

VS 150

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06843 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Berdy Springs, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Md County Baltimore

City or town Berdy Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME LEVI D. WILSON

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife Sarah Elsie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1864

8. AGE: Years	Months	Days	If less than one day
82	5	1	..... hrs. ..... min.

9. Birthplace Packtown, Md. (Town, county, and state)

10. Usual occupation Railroad Employee

11. Industry or business

FATHER 12. Name Thomas Wilson

13. Birthplace White Hall, Md

MOTHER 14. Maiden name Amanda Kersey

15. Birthplace York Pa

16. Informant Mrs. Wm E. Kay

Address White Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25, 1946 (month) (day) (year)

Cemetery or crematory Glatolmelia, Md

Location Parkton R.F.D.

18. Funeral director Howard S. Markline

Address White Hall, Md

19. July 24, 1946 Mrs. Howard S. Markline

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1946, at 7.45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1946 to July 22 1946 and that I last saw h.... alive on July 22 1946

Immediate cause of death	DURATION
Hypertensive Cardio-vascular disease	14 m
Due to Arteriosclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul D. Thayer, M.D.

M. D. or other

Address Shrewsbury, Pa. Date signed 7-24-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06844

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 2 mos., 23 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 4 yrs., 2 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto Co.

City or town: 6615 Liberty Hgts. Ave. Balto., Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6615 Liberty Hgts. Ave., Baltimore, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Zentz

3. (b) Social Security Number: 217-01-0624

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella Zentz

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): September 26, 1894

8. AGE: Years	Months	Days	If less than one day
51	10	4	...hrs. ...min.

9. Birthplace: Carroll Co., Maryland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER — 12. Name: Frederick O. Zentz

13. Birthplace: Carroll Co., Maryland

MOTHER — 14. Maiden name: Kiturah Griffee

15. Birthplace: Carroll Co., Maryland

16. Informant: Charles Zentz

Address: 6615 Liberty Hgts., Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 2, 1946 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Woodlawn, Maryland

18. Funeral director: William Cook, Inc.

Address: St. Paul & Preston Sts., Balto.

19. July 30, 1946 (Date rec'd by registrar) Earl J. Welsh (Jos. D. Mayo) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1946 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7, 1942, to July 30, 1946 and that I last saw him alive on July 30, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	4 Yrs. 8 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Fatal Pulmonary Hemorrhage	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S Shaffer M.D. (M. D. or other)

Address: Mt. Wilson, Md. Date signed: 7/30/46

Rec'd - 8-31-46 E E Nichols m

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.